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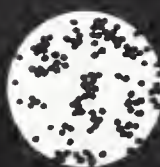
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ALASKA MEDICINE



Official Journal of the Alaska State Medical Association
Official Journal of the Alaska Dental Society

1135 Eighth Avenue, Suite 1, Anchorage, Alaska 99501

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NOTICE:

To synchronize our publication with other journals carrying the same advertisements we have moved the December issue to January. Future publication dates will be April, July and October.

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PRESIDENT'S PAGE

By Edward D. Spencer, M.D.

President

Alaska State Medical Association.

Dear Fellow Alaskan Doctors:

The past few months have been quite eventful in your society as far as your President is concerned.

At the August executive committee meeting it became apparent that our Society had it's financial back to the wall and emergency measures were needed. Accordingly I wrote to Dr. Bornemeier, our A.M.A. President. The Board of the A.M.A. responded by sending Dr. Burt Davis, Chairman of the A.M.A. Board Finance Committee up to meet with the executive committee of our society at Anchorage in September. Dr. Davis was then instrumental in getting our Executive Secretary, Bob Ogden on the A.M.A. payroll for six months, and having the A.M.A. provide certain travel funds. Our society owes much to Dr. Davis. He has been quite helpful, along with several other A.M.A. officials.

Meanwhile we are taking all possible fiscal measures to insure a balanced budget and avoid another crisis when the A.M.A. help ceases. We must develop other sources of income and several promising avenues are appearing.

Since the A.M.A. had been so helpful I was glad for the opportunity to attend the A.M.A.

midyear House of Delegates meeting in Boston November 29th to December 2nd. The principal item of debate was the implementation of more extensive peer review. Third party payment for medical care makes some review mechanism mandatory. I hope Alaska can take the lead in developing peer review mechanisms that will be helpful to each one of us. The peer review committees we develop should particularly consider the quality and appropriateness of care given. Fee review should be but a minor part of the peer review function. If emphasis is placed this way, peer review will be helpful and educational to everyone. Of course we must be sure that such review is truly peer review where a Doctor's work is reviewed by other doctors treating similar types of cases in similar environment. We must also be sure that the intimacy of the Doctor-Patient relationship does not suffer.

In our far flung state it appears to me we will need at least two committees one for Southeastern Alaska and one for the rest of the state. The Social Security Amendments presently before the Senate provide for one committee in areas containing at least 200 physicians. Please consider these things and come to the annual meeting in June ready to carry on an informed discussion.



RECENT POPULATION TRENDS OF ALASKA NATIVES

By Joseph D. Bloom, M.D.

Anchorage

The object of this paper is to examine current population distribution of Alaska natives and to raise some questions regarding the relationship of this distribution to planning of services. There has grown in recent years an increased awareness of the dangers of the population explosion. Nowhere are these dangers more acute than in the Arctic and Subarctic areas of North America where increasing population pressure is putting great stresses on the delicate balance which has existed for thousands of years between man and the limited resources of his northern environment.

The population explosion which will be depicted below has been described by Jenness¹ as the single most important crisis facing the indigenous peoples of the north.

There is clear evidence that the population explosion began in the early 1950's. At that time there were changes in the health care system with the creation of the Alaska Native Health Service. Tuberculosis was the major public health problem with extremely high morbidity and death rates.² In the mid-1950's and 60's there was a dramatic reduction in the tuberculosis death rates and a gradual decrease in infant mortality rates.

According to census data there were 33,863 Alaskan natives in 1950. By 1960 the population jumped to 43,081.³ In 1966 the Federal Field Committee for Development in Alaska estimated the native population at 53,000 people.⁴

TABLE I

Percentage Distribution of Alaska's Native Population by Age

Age	Percentage of Total
Under 5	18.9
5 - 9	15.8
10 - 14	12.6
15 - 19	10.4
20 - 24	7.1
25 - 29	6.8
30 - 34	5.8
35 - 39	5.0

40 - 50	7.9
50 - 60	4.9
60 - 70	2.6
Over 70	2.2

Thus there was a 27% increase in the native population between the years 1950 and 1960⁵ and this rate of increase continued into the 1960's.

The dynamics of this population explosion resulted from a reduction in the death rates without concomittant reduction in the birth rates.

Table one depicts the percentage distribution by age of the Alaska native population according to the 1960 census. This illustrates the youthfulness of the population.

This means that 47.3% of the population is under 15: 57.7% is under 20 and 71.6% is under 30. The median age of the population was 18 in 1960 and 16.3 years in 1966.⁶ These figures are highlighted even more dramatically when contrasted with the overall age distribution of the principal ethnic groups in the United States. These figures are depicted in Table II.

TABLE II

Age Distribution of Principal Ethnic Groups in the United States, 1960⁷

Groups	14 years & under	15 - 19 years	20 years & over	Total
White	48,084,986 30%	11,608,229 7%	99,138,517 63%	158,831,732 100%
Negro	7,085,970 37%	1,496,991 8%	10,590,715 55%	19,173,676 100%
Indian	230,733 41%	49,897 9%	275,392 50%	556,022 100%
Mexican	1,449,629 41.8%	306,979 8.8%	1,708,391 49.4%	3,464,999 100%
American	344,996 38.6%	75,784 8.5%	471,733 52.9%	892,513 100%
Puerto Rican	148,167 31%	31,228 7%	301,032 62%	480,427 100%
Japanese				

This table demonstrates that although the Alaska Native Group is numerically small it has an age distribution which is the most extremely skewed toward the young of any minority group within the nation, including the Indian people as a whole. Some of the native villages show the trend to an even greater extreme than the overall figures for Alaska natives.

Hooper Bay, for example, is an Eskimo village located on the Bering Sea in Western Alaska. In

1950 its population was 307 while in 1966 the population had grown to 535, of which 52.9% were under age 14 and 72.4% were under age 24.⁸

This population increase is taking place despite clear evidence that there is a trend toward movement of people to larger rural cities and to urban centers. Hippler⁹ has presented evidence that the villages of rural Alaska are not diminishing in size or disappearing; if anything, they are growing. Based on a 1966 sample of 12 Eskimo villages in Northwest Alaska, a sample of 2513 people, Hippler presents the following age breakdown: 47% of the population is under 14 and 59.9% of the population is under age 19. This is in line with the 1960 census, showing a slight slowing down in the birth rate but not one of large consequence.

Milan,¹⁰ in a 1968 study of the northern Eskimo village of Wainwright, again presents similar figures. He found that 46.1% of the population was under age 15, and 55.5% of the population was under age 19.

From Hippler, Milan and Fortune there is clear indication that the population explosion extended well into the 60's with little drop in the birth rates occurring in the late 60's. (The Indian Health Service began a birth control program in late 1965 and it is beginning to have an impact on the birth rate.) Hippler¹¹ believes that the population base established during the period of rapid population growth will be sufficient to keep the villages growing, despite a reduction in the birth rates through birth control programs and equal access on the part of the poorer people to the new abortion legislation.

Discussion:

There is thus clear evidence that the native peoples of Alaska have experienced a population explosion of an extreme nature over the past twenty years. This has produced a population structure which is dramatically skewed toward the young. There is also ample evidence that large numbers of people are remaining in the smaller villages along with a general trend toward growth of the native population in the larger rural towns and in the cities.

There are obvious implications of these population trends in the area of governmental planning. Much has been written about the stresses on the native peoples due to problems of cross-cultural contact.¹² The introduction of large numbers of young people into an already strained system will of necessity increase the strain. This increased strain will exist both in the adult native community and in the agencies of government charged with the provision of services to native peoples. Can this increased strain brought about by population pressure be managed?

If the response is to be direct action by government on the local level we have every reason to believe that the answer will not be adequate. Although we have known for years about the relationship between poverty, poor housing, poor health, poor schools and social problems, we seem unable to mount the type of effort, both financially and conceptually, required to alter the problems at their heart. Coordinated approaches aimed at core environmental and social problems are seldom possible given a bureaucracy in which plans are pieced together by disparate and often competing units. This author is quite pessimistic regarding the ability of government to radically reduce the strain by direct programming. Government's best efforts may come in facilitation of local programming.

Can the native people themselves reduce the strain imposed by the population explosion? Without power or financial resources the natives are severely handicapped to help themselves to any significant degree. However, there have been changes in recent years which are bringing more power and resources to the native peoples. Many governmental agencies, with the impetus from the early years of the Office of Economic Opportunity, have begun to allow the recipients of services a greater say in agency policy. There is, as yet, no real relinquishment of centralized control, but as time progresses the "consumers" will become more sophisticated in the manipulation of power. The advisory boards will pass out of existence and be replaced by local boards of control. In this process, power and decision-making will be returned to its original source, local people.

The most important and immediate issue, however, which will return power and money to the local level, will be the settlement of the native land claims. Although the native land claims represents a land settlement issue based on treaty obligations, one cannot help but dwell on their social implications. From the point of view of social planning and community development, the land claims settlement will hopefully by-pass the bureaucracy and deliver resources directly to regional native corporations. This will directly link the people experiencing problems with some of the tools necessary to alleviate them. This is almost unheard-of in terms of social problems in this country, and holds great promise.

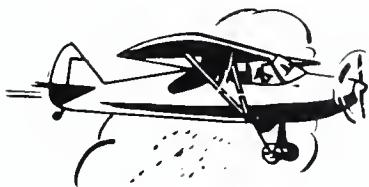
It is the opinion of the author that the population explosion as experienced by Alaska natives is a crisis of major proportions. In the resolution of this crisis lies the key to the future of Alaska. Will we produce a bi-modal society, of have and have-nots, as exists in other parts of this country, or will we be able to truly unify the people of the state? All the seeds for the former are present today. We have large numbers of young

people subject to marginal resources and racial prejudice who are headed for marginality as adults. Traditional governmental answers will not stem the tide, if we use past experience as a guide. Change will come with a return of power to the people. This means a return of their original resources in land and in money. ¹³

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FAA-type Pilot Brief

An often reliable source reports a story circulating in Bush Alaska about a well-known, often lubricated pilot who embarked on a rescue flight to a remote Eskimo village under adverse weather conditions. Villagers heard the drone of the invisible plane passing over in the storm several times. They then noted that the continuous engine roar appeared to have stopped moving and was coming from a stationary point near the village. Donning their furs they made their way toward the sound, only to find the plane firmly embedded in a soft snow drift and almost invisible in the cloud of snow thrown out by the whirling propeller. The pilot was hunched over the stick, hand on throttle, peering out into the passing storm and totally unaware he had landed. It is reported that he required stimulants when a tapping on the side window drew his attention to several smiling Eskimo faces.

ON THE USPHS ROLE IN ALASKA

By Kenneth Behymer, M.D.

Anchorage

I recently entered the private practice of internal medicine after one-and-a-half years as Chief of Medicine at The Alaska Native Health Center here. Many of my new acquaintances in the private medical community have asked me what is to become of PHS in Alaska. Most of them have no contact with the Native Health Service and hear rumors about its future from time to time. I thought I might share with you what I know, have heard, speculate and would like to see.

There are some 50,000 plus Eskimos, Indians and Aleuts in Alaska served by eight Public Health Service (through its Indian Health Service) hospitals. The Federal Government assumes complete medical care of these people. Due to problems of personnel and funding shortages "complete" care is not always possible as you might suspect. For instance the dental care program is primarily for the children — adults only being given emergency care. The "field" hospitals provide a good brand of rural medicine. They are primarily staffed with young physicians serving their military obligation, with older, experienced physicians supervising when available. These men visit villages in their area to hold clinics whenever they can, virtually all villages being visited at least annually. These hospitals, in turn, are visited periodically by specialists from The Health Center in Anchorage for clinics and consultation.

The Health Center functions primarily as a referral center and secondarily as a "field hospital" for Anchorage and its assigned rural area. Adequate specialty staffing is difficult to achieve, so many consultants are used from the private medical community in Anchorage and other Alaskan cities, often on a donated time basis.

"What's to become of PHS in Alaska" really means, what is the PHS's long term mission or goal? For instance do they intend to render free medical care until a certain percentage of the Native population becomes financially competent, or is this seen as a right of Natives for all time in compensation for wrongs committed on them in the past? That decision has not been made and to the best of my knowledge there is no inclination to make such a decision. To decide to perpetuate this program forever would be unpopular, as it would tend to keep Natives segregated from the general

society. To decide to end the program would be asking a department to commit suicide — such a decision would obviously have to be imposed by an outside force. I don't know of anyone who is both interested and influential enough to achieve this. In short, I think that PHS will be in Alaska for a long, long time.

What then, will their mission within Alaska be? I am speaking now of scope of medical care. The most obvious and perhaps most likely course is that nothing will substantially change. The health care system has evolved into a fairly stable organization that is not amenable to radical changes.

Many private and PHS physicians would like to see certain changes. In discussing the Alaska Native Medical Center in such terms as "abolishing", "absorbing" or "moving", one must consider that there are approximately 200 full beds involved. Perhaps as many as a third of these are patients who could have out-patient evaluations, are awaiting transportation, or are recuperating in the hospital because of where their home is. Some of this could be relieved by a medical-motel like facility, but this still leaves over 120 beds involved in the discussion in Anchorage alone. That is a lot of beds in an under-hospitalized town to be discussing without serious forethought.

Unfortunately, the relationship between the PHS's Indian Health Service facilities in Alaska and the private medical community are frequently cool. As best I can gather this is due to differences of opinion and personality conflicts that occurred to a great extent before I came on the scene, but still continue to some extent. In this I'm obviously not completely impartial as I have chosen private medicine over government medicine as a career.

One option mentioned is that the PHS should completely pull out of Alaska. In the past this was most often suggested by those who felt that the Natives should not be entitled to free medical care. The majority of Alaskans have probably never agreed with this last contention — but more do now with the prospect of a land settlement looming. This implies to some people that a financial debt will have been settled with the Natives, who then become equal members of society and no longer entitled to special benefits.

This, in fact has been considered a moot point, since there is no acceptable alternative currently available to Federal Government executed medical care to rural Natives. I have heard it suggested recently that private medicine could indeed handle the rural medical program. The idea was that a group of physicians or a private clinic could contract with the Federal Government to care for the Natives (or in the case of the State, the indigents) in a certain geographical area. They would assume an obligation to visit the villages on a prescribed schedule and perhaps even handle the more serious illnesses that required larger city hospitalization. Transportation costs might or might not be negotiated along with this. The greatest drawback to this is that there just aren't enough physicians in Alaska outside of PHS to execute this plan. This would require at least another twenty physicians and I'm not sure they could be obtained.

Which leads up to another suggestion that is frequently heard among private physicians in Anchorage — that is that the PHS contract out care to Natives in cities where private medicine is available, and continue a rural medicine program. The arguments favoring this are twofold — one that PHS mission has always been more oriented to rural medicine, and that the Federal Government should support and not compete with local medicine when it is available. Both of these “points” are opinions and not points.

A compromise to this same suggestion is that the PHS join an existing hospital or the community in building a joint hospital. The private medical community favors this option strongly for many reasons. It would bring more federal funds into building and maintaining a community hospital. It would bring private and government physicians closer together and presumably improve relations. It would give private physicians more access to Native patients who they would like to become acquainted with and treat, and no doubt some feel that this would be a foot in the door to eventually squeezing PHS out of Anchorage. The PHS sees this idea as a mixed blessing. It would by virtue of proximity give them more access to the greater number of specialists that exist in the private community. No matter what justifications and rationalizations one chooses to use, this plan would undoubtedly require the PHS to spend more

money than it now does. This money, ultimately would have to come from Congress. They probably would sponsor such a thing if someone or group of someones spent a lot of time preparing and presenting such a plan along all the channels of PHS that are required. I do not know of anyone who believes in this concept strongly enough or is interested enough to pursue this course. The greatest attraction of this concept to me personally is that it would “desegregate” Native medical care to an extent. I favor any move that brings Native Alaskans into more direct contact with the rest of American society.

Another interesting concept of Native medical care is that the whole concept should be abolished. That this state, like any other state, should render free medical care to any indigent whatever race he belongs to. The difficulty with this concept is, that by our society's definition, the majority of Natives would be considered indigent. A state as sparsely populated as Alaska just does not have the tax base to support such a large welfare program. An alternative suggestion is to ask the Federal Government to give money to the state which in turn would assume the role of the current PHS facilities. I suspect that this would just add another level of bureaucracy. The only advantage I see in this is the possibility of adding some local decision making.

I hope the rest of Alaska will forgive me if my discussion is too Anchorage oriented, but this is where I live and work and take my orientation.

It must be obvious by now that I favor combined PHS — community hospitals, for reasons stated earlier.

I would like to challenge our local Alaskan PHS officers to support this goal, since I believe that it would inevitably bring better medical care to Native Alaskans. It will probably require a lot of “supporting” on your part to get the necessary financing.

I would like to challenge the private medical community to make more positive suggestions. This requires a lot more ingenuity and imagination than it does to find fault.

I would like to challenge the Alaskan Natives to formulate some definite opinions on this matter and pursue them vigorously. Decisions are being made concerning your welfare and you may as well have some say in what happens.



HEALTH CARE PLANNING - ALASKA, 1971*

By Rodman Wilson, M.D.

Anchorage

What we most need to know is whether or not Alaska natives will continue to receive medical care from the Indian Health Service, USPHS, under a native land claims settlement. Until this is decided, we should plan for either eventuality. The principals involved, namely, native leaders, the Department of Health and Welfare, the U. S. Public Health Service, and the Alaska State Medical Association, with help from other groups, such as the Alaska Hospital Association, the Alaska Dental Association, the Alaska Nursing Association, and the Alaska Pharmacy Association should meet in work sessions to devise plans for the care of all Alaskans. This should be done under the auspices of the Comprehensive Health Planning Advisory Council, but not necessarily under any particular present committee of the Council. At this moment experts are needed more than consumers. The latter, being a majority of the Council, can eventually judge the plans.

The State can help in this vital planning by increasing the budget of the Council so that it can hold many more meetings.

Congress can help planning for future health systems in Alaska by:

1) Enacting a bill similar to S.2241, Remote Health Facilities Act, to give more flexibility to rural health care planning by making USPHS facilities equally available to non-native patients and available to non-USPHS health professionals.

2) Changing Public Law 89-749, Comprehensive Health Planning, to require that governmental medical activity such as by the USPHS, Veterans Administration, Armed Services, Office of Economic Opportunity, Regional Medical Program, and the like all come under the purview of state comprehensive health planning. How can planning be "comprehensive", particularly in Alaska, when government medical programs are exempt? By definition, planning is not "comprehensive" under these conditions.

3) Providing more federal money to comprehensive health planning councils to study the impact of national health insurance upon health systems within each state. S.4297, Health Security Act (Kennedy) provides for extra federal support to state planning councils but only upon

enactment of the bill. Since national health insurance in some form seems inevitable, states should be studying its implications now, not after enactment.

National health insurance, incidentally, would undoubtedly allow all individuals, native or non-native, freedom to seek medical services from any existing system. There would be substantial cross-over of natives, particularly in cities, to private care. The result, as with veterans, would be that native individuals would move in and out of public or private systems as they were pleased or disgruntled with one or the other. This is enormously expensive and wasteful of the health dollar and professional time. The Alaska State Medical Association believes that manpower and facilities can be developed within the state to provide medical care, both in rural and urban Alaska, on a racially non-segregated basis.

Finally, in designing national health insurance the Alaska State Medical Association suggests that Congress consider extinguishing special favor medical programs such as exist for veterans, seamen, victims of industrial accidents, and military dependents. If everyone has full care under a national system, then there is no need for duplicate systems to persist with their inefficiencies, their eight-to-four-thirty doctors, and their fiscally open-ended, politically influenced programs. These, too, should come under the price fixing, rigid budgeting, and cost controls proposed in national health insurance systems. Since most modern Veterans Administration hospitals are built adjacent to medical schools, there would be no problem in using these to care for all individuals. Job injuries could be cared for under the same national health insurance system. Dollar motivated casuistry to establish job connection or aggravation might end if these cases were handled just as any other illness or injury. Job injuries could still be

*Summary of remarks made to Alaska Congressional Delegation at Alaska Department of Health and Welfare Health Caucus, November 30, 1970, Anchorage, by Rodman Wilson, M. D., Chairman, Legislative Committee, and member of Bush Medicine and Public Health Committee, Alaska State Medical Association.

counted for purposes relating to industrial safety and perhaps for final awards for permanent disability.

In summary, Congress can help in planning for the health needs for all people in Alaska by enacting a bill similar to SB.2241, Remote Health Facilities Act, to make Public Health Service facilities in rural areas available to all individuals and health professionals, native or non-native; by requiring that government health agencies such as U. S. Public Health Service, Veterans

Administration and the like be required to come under the scope of comprehensive health planning; by providing more federal support for comprehensive health planning; and by making sure that government health programs having to do with the care of individuals such as veterans, seamen, individuals injured on the job, and the like, are included under whatever unified national health insurance program is enacted, rather than continuing as special favor programs.

BOOK REVIEW

The Mirages of Marriage. By William J. Lederer and Don D. Jackson, M.D. 453 pp. New York: W. W. Norton and Company, 1968. \$8.50.

The Mirages of Marriage by William Lederer and Don Jackson is a comprehensive overview of marriage as looked at in the context of "Systems" Theory. The basic assumption of this theory is that the marriage or the family is a functioning unit, and that, as a unit, it finds its own equilibrium. It assumes that each of the members of a marriage or family contributes in their own way to the equilibrium of the larger unit.

This work is a very readable piece, which could be understood and enjoyed by professional and layman alike. It systematically presents both the difficulties and solutions to the marital bind. It begins with the false premises upon which many marital unions are based, then conceptualizes the spectrum of marital interactions as well as outlining many of the common destructive elements in marriage. The book closes by suggesting how to change this equilibrium by communication and by the establishment of a quid-pro-quo. The authors define a quid-pro-quo as a set of reciprocal interchanges. They show that if a couple can communicate reciprocally that their communication will be reasonably clear, and they will thus avoid many of the major common communication blocks.

Marital counseling situations arise in all medical practices, and every physician is expected at one time or other to be an expert in this very confusing field. There has been very little written of cogent practical value to the practitioner forced to deal with a disintegrating marriage, and many physicians are forced to deal with these situations without the benefit of a workable framework. If this work is well digested, and the practitioner is able to apply the theory, then he will have a reasonable construct within which to channel his own comments, and also one

which he can recommend to his patients. With this in mind, this book is extremely worthwhile reading for all in the medical profession.

Aron S. Wolf, M.D.

Clinical Gastroenterology. By Howard Spiro, M. D. Price \$35. Pp 1011, appropriate black and white illustrations. The Macmillan Company, 866 Third Avenue, New York, 10022.

This text, in its first printing, encompasses well the field of gastroenterology. Although humbly written, it reflects the author's wide experiences within his chosen field. He presents the material in an easily readable form, which reflects his practical approach to the evaluation and care of the gastroenterologically diseased patient. He does not apologize for the greater emphasis placed upon the more commonly seen diseases but, also, he does not restrict the inclusion of the more exotic ailments.

The book is divided into nine basic units, each including topics related to a major organ of the gastrointestinal system. The last unit, entitled "Miscellaneous Considerations," includes diseases which could not be well classified and incorporated into an earlier unit.

Each topic within a unit is judiciously referenced with material of recent vintage from journals readily available to most physicians. Clear and distinct photographic illustrations are included where necessary to clarify the text.

As in many texts, this work is not all inclusive, as noted by the failure to include, under treatment of the age-old amebiasis, use of the newer drug Metronidazole (Flagyl), described in recent literature.

With its easy readability and practical, comprehensive approach, this book will make a valuable addition to any library.

Gilbert Blankinship, M.D.

BOOKS RECEIVED

The Early Orthopaedic Surgeons of America, by Alfred Rives Shands, Jr. M. D., The C. V. Mosby Company, St. Louis, 1970, 190 pp., \$15.00.

Essentials of Clinical Endocrinology, by Norman G. Schneeberg, M. D., The C. V. Mosby Company, St. Louis, 1970, 449 pp., \$22.50.

Handbook of Legal Medicine, by Alan R. Moritz, M. D. and R. Crawford Morris, LL.B., Third Edition, The C. V. Mosby Company, St. Louis, 1970, 238 pp., \$8.75.

Control of Gastrointestinal Function, by Frank P.

Brooks, M. D., ScD. (Med)., The Macmillan Company, New York, 1970, 222 pp., \$7.95.

Control of Energy Exchange, by Loren D. Carlson, Ph. D. and Arnold C. L. Hsieh. M. D. D.Sc., The Macmillan Company, New York, 1970 151 pp., \$6.95.

The Adolescent Patient, by William A. Daniel, Jr., M. D., The C. V. Mosby Company, St. Louis, 1970, 444 pp., \$20.50.

Hernia Repair Without Disability, by Irving L. Lichtenstein, M. D., The C. V. Mosby Company, St. Louis, 1970, 210 pp., \$26.50.

ALASKAN DENTISTRY IN THE BUSH, ITS MEAGERNESS

By Robert F. Brodie, D.D.S.

Anchorage

All indications are that in the next few years Health Care will be in the center of the political stage. The great debate on National Health Insurance is due to begin in the next Congress. The heart of the matter is simply that there are many Americans who are not receiving even rudimentary health care. Since no one else has solved the problem the Congress will attempt to do so. Unfortunately Alaska is no exception, in spite of the fact that governmental Health Care has been available for the "poor", Alaska's rural natives, from the beginnings of the Bureau of Indian Affairs to the current administration of the U. S. Public Health Service. To be sure there have been major advances in reducing polio, tuberculosis, other diseases and infant and maternal death, all to the credit of the men and women who made it possible.

However, with the passage of time this same governmental Health Delivery System has lapsed into the cardinal sin of all bureaucracies: The system is now more important than the patient. Evidence of this is manifold: 1 — Manpower is concentrated in the metropolitan areas at the expense of and to the detriment of the rural patient. We are told that housing is more available in the metropolitan areas, yet state teachers are widely distributed throughout the bush. 2 — When funds have been cut in recent budgets it was rural services and people that were deleted. 3 — Administrative costs outweigh the costs of services delivered by unbelievable proportions. 4 — We now have a new government agency on the scene, The Office of Economic Opportunity, to provide the care and services neglected by the rural policies of another government agency. 5 — Compounding the problem, the Public Health Service has created a situation throughout rural Alaska that can only be called segregated Health Care.

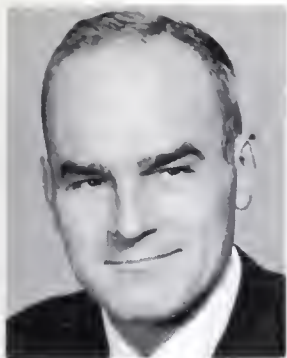
Where a civilian practitioner can go, USPHS has a station which makes it economically impossible for him to practice without contract care cases, while at the same station they treat only native patients on a very limited basis termed "incremental care". Where the civilian practitioner cannot go — they do not go either, leaving whole areas (Wade Hampton, Yukon-Kuskokwim) devoid of reasonable dental services. Everywhere in the

bush non-native patients must settle for "emergency" care, primarily extractions.

How then could this trend be reversed? How could suitable Health Care, on a par with city care, be delivered in the bush? How can areas like Wade Hampton and Yukon-Kuskokwim be made more attractive to dentist and physician?

Two important and effective steps toward better dental health for Alaskans should be initiated without significant delay. First, relocation of PHS health professionals from metropolitan areas to the areas of greater need. Second, make contract health care available to the Alaska Native anywhere in the state. This would provide the great majority of the Native citizens of Alaska access to adequate dental care for the first time. Surely this can be done in the same manner that the VA operates (i.e. by prior authorization) until such time as an adequate national health insurance program is enacted. Enough private dentists are available to make a good start right now. These patients desperately need care. Why not act?

ELECTION DISTRICT		POPULATION July 1, 1969	Civilian Dentists	FEDERAL PHS	M
ALASKA		294,560			
1	Ketchikan-Prince of Wales, Total	14,910	4	1	1
	Ketchikan (2)	12,810			
	Prince of Wales (1)	2,100			
2	Wrangell - Petersburg (3)	5,970	2	0	0
3	Sitka (4)	7,770	3	4	0
4	Juneau (5)	13,330	8	2	0
5	Lynn Canal-Icy Straits (6)	3,620	1	0	0
6	Cordova-Valdez, Total	4,540	1	0	0
	Cordova-McCarthy (7)	2,240			
	Valdez-Chitina-Whittier (8)	2,300			
7	Palmer-Wasilla-Talkeetna (9)	7,000	3	0	0
8	Anchorage (10)	114,150	57	11	55
9	Seward (11)	2,700	1	0	0
10	Kenai-Cook Inlet (12)	13,550	4	0	1
11	Kodiak (13)	9,870	2	0	4
12	Aleutian Islands (14)	8,660	1	0	7
13	Bristol Bay (15)	5,040	0	1	0
14	Bethel (16)	7,750	1	2	0
15	Yukon-Kuskokwim, Total	6,780	0	0	0
	Kuskokwim (17)	2,850			
	Yukon-Koyukuk (18)	3,930			
16	Fairbanks-Fort Yukon, Total	48,900	16	2	28
	Fairbanks (19)	47,320			
	Upper Yukon (20)	1,580			
17	Barrow-Kobuk, Total	9,060	0	2	0
	Barrow (21)	4,480			
	Kobuk (22)	4,580			
18	Nome (23)	6,390	0	2	0
19	Wade Hampton (24)	4,570	0	0	0



R. A. Smithson, D.D.S.



AURORA DENTATUS

ANCHORAGE

Dr. Thomas G. White is now associated with Dr. Robert Smithson at 825 L Street in General Dentistry.

Dr. Curtis Menard is now with Dr. Luther Paine at 2550 Spenard Road, associated in General Practice.

Dr. Darrell Kester is established at 4050 Lake Otis Parkway, General Dentistry.

Dr. Bryan Saario has opened his own office at 1020 West Fireweed for the practice of Oral Surgery.

Dr. Kenneth J. Mears has associated with Dr. Robert Sutherlin at 837 W. Northern Lights Boulevard for the practice of Orthodontics.

Dr. John Sargent is practicing General Dentistry in Eagle River.

The Executive Committee of the Alaska Dental Society is engaged in a series of discussions concerning a State Dental Director. Learn the pros and cons and make your wishes known to your officers.

KENAI

Dr. John McCarthy's back from a holiday.

Dr. Chuck Bailie is happily working in his new office, also reports that their 8 year old girl broke her leg just before Christmas.

KETCHIKAN

Drs. Aubrey Stephens and James Shaley have joined the incorporated practitioners.

Dr. Wally Connell completed his Orthodontic training recently and for the past couple of months has been busily establishing himself both in Juneau and Ketchikan.

JUNEAU - Norm Riddell - Correspondent

Dr. Clayton Polley is about to head South on his annual pilgrimage to Southern Oregon and California. He intends to shop for a garden tractor. It seems the idiot stick is obsolete for Juneau's best gardner.

Bob Horschover has recently returned from S. E. Asia where he attended the Asian Pacific Congress of the F.D.I. He also visited Dental and Medical Schools and was pleased to see the fine work being done, but somewhat surprised to see mostly females in the Dental Profession. His report as Delegate to the A.D.A. convention is forthcoming.

Dr. Richard Williams had some heart problems last fall and has moved to 225 Mt. Hermon Road 147, Santa Cruz, California 95060. He would be pleased to hear from us. Dick's Orthodontic practice is now being cared for by Dr. Wally Connell in the same location.

Dr. Wayne Putnam and Dr. Jerry Zimlicka are officing together in Mendenhall Valley. Two more good men for Juneau!

FAIRBANKS - Arnie Pflugrad - Correspondent

The holidays found: Dr. Carl Higgins with family in North Carolina. Dr. McDonald in Montana. Dr. Gene Kusch outside somewhere. Dr. Arnie Pflugrad trying to relax in Mazatlan and coming home not sure he'd had a rest; even the hotel rates were like Fairbanks.

Welcome to Dr. Arthur Hensen and his fine new office on Airport Way.

Dr. Fred Bast is now associated with Gene Kusch in their new offices in College.



INFLATION AND THE PHYSICIAN

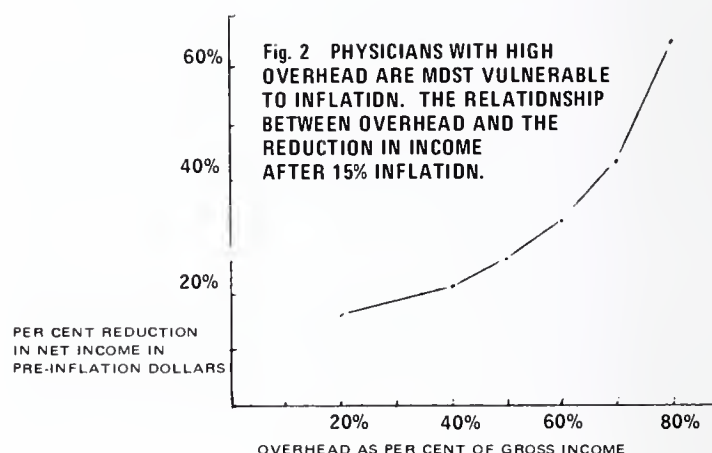
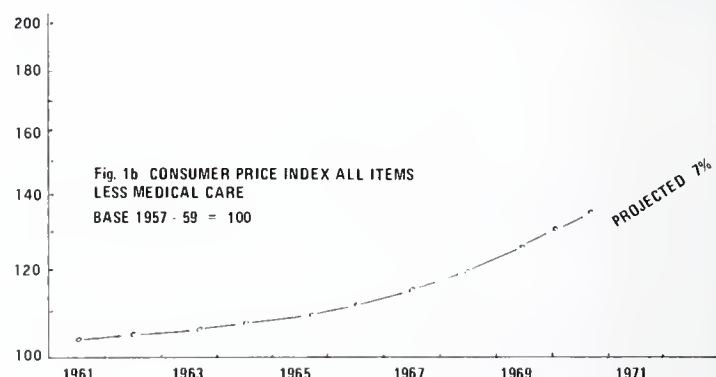
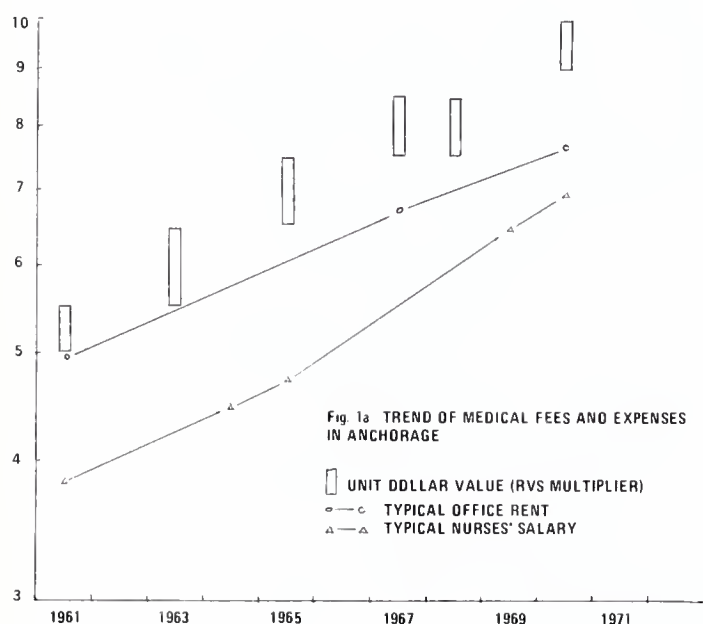
By F.J. Hillman, M.D.

Anchorage

The cost of living has increased 15% from January 1968 to September 1970, as shown by the U. S. Department of Labor Consumer Price Index, ^{1,2,3} which has risen from 117.3 to 134.8 (reference base 1957-59=100). See Fig. 1. These are average national figures, are not specific to Alaska nor to socio-economic level, but probably give a fair indication of local changes.

Fig. 2 shows a graph of changes over the past decade in Anchorage of typical office rents, nurses salaries, and multiplier factors for the California Relative Value Study (used by many physicians as an aid in determining fees). Physicians fees, which were low in Alaska in the early 1960's relative to the nation, rose abruptly in the mid-60's, about the time that the 1964 Relative Value Study came into use. Since then fees to private patients probably have kept pace, so far, with the rising cost of living.

During inflation, so long as wages rise in proportion to the cost of living, real wages are the same and all that diminishes is the value of one's accumulated capital (savings, life insurance, securities, etc.). History shows, however, that in periods of inflation wages usually lag behind rising living costs. Real wages are then, in effect, diminished in regard to the goods and services they can buy.



Physicians are especially vulnerable to the effect of inflation because of the effect of office "overhead" expenses. If fees (and therefore gross income) rise in proportion to overhead, the net income is inflated in dollar amount but remains the same in "real" (ie pre-inflation) value. If, on the other hand, fees remain stable, the increasing overhead reduces net income. Net income in turn loses "real" value because of inflation. A hypothetical example (Table II) illustrates this important point. Assume gross income of \$200, overhead costs of 50% and inflation of 15% (Jan. 68 to Sept. 70):

If fees are stable (second column) an inflation of 15% results, not in 15% loss of net, but in 26% loss of net, because of the loss from inflated overhead to which is added the loss of purchasing power of the net. Conversely, if a physician expects his income to keep pace with inflation, it is essential that his fees inflate at the same rate. (Third column).

TABLE II

The effect of inflation on net income, assuming stable gross income (column 2) and inflated gross income (column 3)

	(1) Jan. 1968	(2) Sept. 1970	(3) Sept. 1970
Gross income	\$200	\$200	\$230
Overhead	100	115	115
Net income	100	85	115
Change in net from Jan. 1968		-15	+15
'Real' value of net in 1968 dollars		74	100
Total change in real value of net		-26	-0-

The loss in "real" value of net income when fees are stable and overhead rises is related directly to the degree of inflation and the amount of the gross, as shown in the formula:

$$\text{Reduction in "real" income} = \text{gross income} \times \frac{(1 - I)}{1 + I}$$

where I is the amount of inflation in percent.

Inflation can be compared to a novice skier starting down a steep slope. So long as he is in control, the run is exhilarating; when he loses control the thrill may end in a tangle of broken bones. Inflating⁴ of the national money supply is planned, according to Keynesian economic theory, by the government for the purpose of economic expansion, and is mediated by the banking policies of the Federal Reserve System, which creates money by buying government bonds. In simple terms the government stimulates the economy during times of recession by fiscal and monetary policies, and restricts it by taxing during times of prosperity. The economy, however, has proved to be subject to other unplanned, powerful, and largely uncontrollable influences. Raising taxes during times of prosperity (essential to the Keynesian argument) has proved politically inexpedient. Powerful labor unions have been able to increase wages out of proportion to productivity. Corporations have been willing to accept increased labor costs because of their ability to increase prices, as a wage and price rise is usually less harmful to profits than a plant shutdown. These and other unplanned and uncontrollable factors are like the icy crust, the hidden sitzmark, or the weak ski binding that cause a skier to come to grief. The overall result is price and cost inflation, ever increasing and out of control. The national average cost of living increased 7% during the 12 months ending Sept. 1970. The reader is invited to make a prediction whether the rate of inflation will increase or decrease from this figure over the next few years, given the attitudes of those in the nation holding economic power toward full employment, taxation, wages profits, controls, balance of payments, interest rates, the

national debt, the role of the Federal Reserve System, etc. To this observer the political and economic climate does not favor voluntary planned deflation. At an annual rate of 7%, in 5 years the consumer price index will have risen from 135 to 190, an increase of 40%. The reader is also invited to calculate his 1976 net income assuming a 40% increase in his present office expenses and assuming no increase in the level of his fees. The net income should then be multiplied by 0.7 to convert it to 1970 purchasing power. During 1969 the cost of operating solo doctors' offices rose 14 percent, as a national average, double the rise in the cost of living.⁶ In the same period their net income rose less than 10 percent. To be more realistic, the reader should project the figures for his own office for 5 years, then repeat the exercise assuming no increase in fees.

The chief beneficiary of inflation, planned or unplanned, is the government, which can thereby monetize its deficits (print paper money to pay its debts) via the Federal Reserve System. The chief victims of inflation are persons with fixed incomes, and those with accumulated capital - savings, life insurance, securities, pension funds, etc. (ownership of common stocks, once thought to be a hedge against inflation, has not always proved to be so in other countries, or in our country in the past⁴). If the chief beneficiary of inflation is the government, and the chief victims are its citizens, then inflation can be thought of as hidden tax - unlegislated, regressive, and largely out of anyone's control. The Social Security Administration and Aetna Insurance Company (the Medicare carrier) are now using January 1968 as the basis for standard fee profiles. A physician who is still being paid January 1968 fees in late 1970 is being taxed twice. His net earnings are worth 15% less, while his overhead is 15% more. The physician whose net income is being squeezed by inflation can defend himself in four ways - all of them either unattractive or difficult: he can raise fees, he can see more patients, he can cut his overhead, or he can find some other way to make a living. The largest items in his overhead - rents, salaries, supplies, and car expenses - are difficult to reduce in a time of inflation, and all are rising faster than the average cost of living. If prevented from raising fees, most physicians, I predict, will solve their problem of an ever-diminishing income by some combination of working harder and cutting corners. They will see more patients, spend less time with each patient, offer less service, dictate briefer reports and case records, spend less time in study and reflection, and spend less money and time on continuing education. Attempts to do any of these may masquerade as "efficiency" but if carried far enough will result in a qualitative change for the worse in medical care.

The "inflation effect" of diminished net income is most marked when overhead is high in relation to gross (Fig. 2). The most vulnerable physicians are those with the highest overhead — pediatricians, internists, and general practitioners. Since groups tend to run high overhead costs, groups will not be immune to this malady.

The necessity for medical fees to keep pace with overhead in order to allow physicians' income to keep pace with the cost of living is not understood by the public, by medical insurance carriers, or by government officials. Yet fee control in a time of inflation, like a loaded pistol in the hands of a child, has potential for unplanned disaster. It could reduce the numbers of physicians of all kinds at a time when there already is a shortage. It could redistribute physicians, when there already is maldistribution, without regard for patient need. It could change completely the character, desirability, and availability of specialty practice, and likely would destroy the specialties of pediatrics and internal medicine as we know them. It could result in different types of persons being attracted to the field of medicine, differently motivated, who could tolerate restricted freedom of decision and action. Inflation plus fee control, in short, could result in a total restructuring of the patterns of medical care both in quality and in quantity, but without any planning, direction, or regard for the medical needs of the nation.

The next several years doubtless will see, in addition to increasing inflation, continuing attacks on rising medical fees by persons and groups who are not necessarily interested in physicians' net incomes, their working hours, or the quality of care

which they provide. Physicians should be alert to the effects of inflation on the economics of their medical practice. For the sake of the quality of medical care in the U. S., as well as in their own self interest, they are urged to resist attempts to control their fees by third parties until the basic causes of inflation are under control.

SUMMARY

The national average cost of living has risen more than 15% since January 1968, which is the date that the Social Security Administration is using as the base line for establishing standard medical fees. Physicians are especially vulnerable to inflation not only because their net earnings lose in real value, but also because their overhead expenses may inflate faster than their fees and gross income. Inflation may prove to be an effective, though unplanned and detrimental, force in the restructuring of American medical care.

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ON THE NATIONAL HEALTH CARE CRISIS

By A. von Hippel, M.D.

"We are facing a national health care crisis of unprecedented proportions."

"Our entire health care system needs radical revision."

As our great recreation industries tool up for the unprecedented demands expected to result from the four day work week, the public has decided to settle for nothing less than a large number of low cost, high quality physicians providing 24 hour diagnostic and therapeutic coverage on a seven day week basis. The public is informed as never before on matters medical. They will no longer be put off with long waits, sugar pills and half-truths.

No day passes without the physician being attacked verbally or in print by the media. Our patients know of our incomes but do not understand our overheads. They detail our drawbacks but ignore our daily triumphs. They catalogue our geographical maldistribution while ignoring our educational, financial, and human needs. They attack our increasing reluctance to enter family practice while insisting upon only the most specialized care for themselves.

Physicians are castigated for not "cleaning their own house of incompetents" by the very legal brethren that make this patently impossible. What busy practitioner can afford to be involved in the libel suit sure to follow any attempt to restrict or eliminate an incompetent physician?

We hide behind our ethics, our rules against advertising. We feel that to unionize or strike is unprofessional. We cling vainly to outmoded status symbols such as the physician-patient relationship long after the courts, the legislatures, the lawyers, the compensation boards, draft boards, insurance forms, tax returns, and patients have rendered them meaningless. Somehow goodness shall triumph. Or shall it? Or is it?

The pressure to recognize the physician as an incompetent money grubber is so great that sometimes we sigh and say, maybe they're right. I'm not that way but I guess many of the others are. Maybe something should be done. Maybe we deserve it. What is it?

In his article on fixed overhead and progressive inflation Dr. Hillman clarifies a simple, often vaguely understood truth. Your overhead is

going to get you if you don't watch out. * He also hints at who will be hit first and how low.

Let us assume that a National Health Insurance of some sort is inevitable. Further, that it will be patterned on, or at least benefit from the "mistakes" of Medicare and Medicaid. Lastly, assume that inflation will continue to get worse. All reasonable assumptions.

Those physicians in specialties where the overhead runs 40-60% of their gross income, such as some general practitioners, most internists, and most pediatricians, will note one day soon they can no longer "make ends meet".

What then? Well, they could start with the "ends" closer together, that is, reduce their standard of living and expenditures. Admittedly, most physicians may have a little slack here, but not too much, not as much as most people would like to believe, and the end of the belt-tightening phase will come soon in the stable fees-inflation pinch.

They could pad the insurance bill to balloon the fee. This is called "cheating". But if the insurance company decides to deflate their fee, that is "fiscal responsibility".

They could cheat the patient by performing unnecessary tests or procedures or by reducing evaluation times to absurdly low levels. That is, they could stop practicing quality medicine.

OR, they could work longer hours for lower pay. No need to consult the wife and kids on this, they never see you now.

OR, take one of those nice new 9:00 A.M. to 4:30 P.M. administrative jobs.

OR, quit medicine. Many practicing physicians have other skills which might even now give a better return for time invested, and more regular hours.

But wait! There is a faint brownish light at the end of this smelly tunnel. We can all join Group Clinics. Just as the bureaucrats always knew we would. How could they know that this was best, those medically-ignorant payroll-padding faceless power-hungry don't-rock-the-boaters? What great benefit do they see in the group practice of medicine that escapes our most careful inspection?

*See also Quebec under Muktuk Morsels this issue.

Lower Cost? It is common knowledge that a person doing his thing under his own responsibility puts out a little extra, does without the extra help, and draws the benefits of this.

Quality Control? Everyone must strive for the same level of mediocrity in a clinic. The group shields the individual physician.

Hours? We're all too busy now, caring for our own patients. But if we join group clinics we can work shorter hours and save lots of time by seeing each others patients instead.

Too many sick patients? Why not take off for a medical meeting or use part of your guaranteed holiday time. Never could do that before, could you?

Referrals? You say your fellow doctors and patients don't like you. Don't worry. In a group you'll get plenty of referrals. They have to go to you. Otherwise the group loses money and the patient loses money. All those names on the clinic door? With that many doctors the patient is sure going to think he is getting just the right one for his disease or non-disease. But we know better. He just gets the guy who isn't busy. After all, it doesn't pay the good docs or the busy docs to get busier. In fact, if we can go paramedical, he gets one of those. It's our system, love it or leave it.

Why should it be our system of medical care if it is not proven cheaper? If, in fact, the care may well be worse? If, in fact, most patients and most doctors prefer the present admittedly imperfect health care delivery system. (Don't burn your present home to collect the insurance until you're sure you can afford the new one.)

How do I know they prefer private doctor and private patient status? Well, if the group clinics are so great, how come there are so few. Oh, there will be more soon when inflation and overhead meet, but that is simply an economic equivalent of the eradication of the Kulaks by Stalin.

Why get rid of the small employer; why kill the free enterprise system even dead and concentrate power further from the people, the patients . . . ? Because the mindless, faceless, ever more powerful bulk of our growing bureaucracy cannot deal with us as long as we are independent and free to criticize. Maybe they are jealous? Most likely just afraid and uncomfortable. Bureaucrats like to deal with administrators. They like cozy deals and arrangements, and hate exposure, ridicule, and unexpected resistance. The private doc hasn't played their game. But they are gathering the strings and soon we'll all dance by the numbers. The inflation-overhead-National Insurance game has started.

As a class of employers our time is short. As employees we will be cooperative, courteous, and quiet. If Ralph Nader had a job with Lockheed do you think the company could afford to let him criticize the government? Do you think a clinic will let member doctors raise hell with the bureaucracy when a new contract is to be negotiated soon?

So National Health Insurance costs more, so Group Care costs more, so the doctors work less and it takes two years to get a hernia fixed, like in Sweden. At least we'll all be pulling together as one big happy health team, with the bureaucrats under an umbrella at the coxswain position.

Why haven't our patients protected us? "Medical care is a right, not a privilege." Maybe so, but that is an expensive right. Buy that right on time payments? O.K., but no interest, that is unprofessional. Default on payment? O.K., since I cannot repossess your appendectomy.

Maybe medical care is a right, but so are reasonable living standards, working hours, and income for the physician. Or maybe a different class of people should go into medicine. How about training high school dropouts to do brain surgery in only six months? You'll get what you pay for!



CARDIAC PACEMAKERS

By James A. Baldauf, M.D.

Anchorage

The Stokes-Adams attack originally described as a syncopal episode associated with a slow pulse is a dreaded cardiovascular entity because of the accompanying high incidence of sudden death. It is now known that the unconscious episode is commonly a complication of heart block and the mechanisms responsible for the syncope include failure to establish an idioventricular pacemaker, asystole during the transition of sinus rhythm to heart block, and superimposition of ventricular tachycardia or fibrillation on pre-existing heart block. The definition of the Stokes-Adams seizure has been expanded by a number of authors to include cardiac conditions other than heart block which produce episodic cerebral ischemia due to the diminution of cardiac output, e.g. calcific aortic stenosis, bradyarrhythmias, idiopathic tachyarrhythmias, atrial myomas, etc. This article will mainly be concerned with the application of cardiac pacemakers in the treatment of heart block, the causes of which are multitudinous.

Primary heart block is probably responsible for over 50% of all complete or intermittent heart blocks and is associated with fibrosis or sclerosis of the conduction system often with no demonstrable adjacent myocardial disease. The etiology of this as implied is unknown. Some other causes of heart block include:

- 1.) Valvular heart disease - calcific aortic or mitral, secondary to rheumatic or degenerative heart problems.
- 2.) Post-surgical - following open heart repair of VSD, Tetralogy of Fallot or AV communis defect.
- 3.) Infections - bacterial endocarditis, diphtheria, syphilis, Chagas' disease, etc.
- 4.) Drug intoxication, digitalis, quinidine, propranolol, procaineamide, guanethidine.
- 5.) Electrolyte imbalance, hyperkalemia.
- 6.) Miscellaneous - sarcoidosis, rheumatoid arthritis, lupus, myocarditis, myxedema, amyloidosis, muscular dystrophy, etc.

Heart block complicating acute myocardial infarction ranges from 3.2% to 18% in reported series,² and is another important cause. Cardiac

pacing is an accepted medical mode for managing heart block today but its inception dates back to the early nineteenth century.

In 1819, Aldini³ attempted direct stimulation of the heart of decapitated criminals and recommended galvanism for syncope. Through the ensuing years many investigators pursued the idea until Zoll,⁴ in 1962 showed the clinical feasibility of closed-chest cardiac stimulation, a method no longer employed. In 1957 direct myocardial stimulation was used to combat heart block resulting from open heart surgery. In 1959, endocardial pacing was successfully initiated on a patient by Furman.⁵ In that same year Greatbatch patented a pacemaker which was successfully imbedded as a permanent device by Chardack⁶ in 1960. Since then many modifications and innovations have arisen in this field.

An electronic pacemaker has at least four parts.

- 1.) An energy source which usually is a mercury-zinc battery.
- 2.) A timing circuit which determines the impulse duration and repetition rate.
- 3.) An output circuit regulating the output energy.
- 4.) An electrode system to couple the output energy to the heart.

The energy source, timing circuit and output circuit are contained within the pacer or pacemaker. Non-competitive (demand or triggered) pacemakers contain additional circuits in the pack. The electrode system allows the electrical energy from the pacer to flow in the tissues. This usually consists of exposed electrodes connecting to the pacer through insulated wires. These electrodes can either be sewn (transthoracic) to the epicardial surface or passed to the endocardial surface of the right ventricle transvenously. The transthoracic approach is employed only for permanent pacing or occasionally post-operatively as a temporary measure in open heart surgery. The transvenous approach is the most commonly employed method used for implanting permanent electrode wires today, and in this instance, the cephalic vein is the

usual site of entrance whereas the subclavian, jugular, median basilic and femoral veins are used for situations requiring temporary pacing. We are currently using the subclavian route for temporary pacing. Since all pacer systems need at least two poles to allow current to flow, two electrode systems have evolved to satisfy this basic requirement.

The unipolar system consists of one insulated wire with an electrode (serving as the cathode) located at the catheter tip. The anode is located elsewhere in the body and is usually a metal plate attached to one side of the pacer. Manufacturers producing this type of catheter include the Cordis Corporation, Elema Corporation and Devices, Ltd.

The bipolar system uses two insulated catheter wires with both electrodes (cathode and anode) located near the tip. Manufacturers producing this type include Medtronic, Inc., General Electric Company, and Electrodyne.

The advantages of one lead system over the other seems primarily one of individual preference. The type of system employed is dictated by the choice of the pacer used. There are several main basic types of permanent pacemakers made and these are the asynchronous, synchronous, R-triggered and R-inhibited pacers.

The fixed-rate pacemaker (asynchronous, competitive) produces regularly timed stimuli yielding a fixed cardiac rate independent of cardiac events. The rate is usually pre-set prior to implantation but in some types (Medtronic) may be changed after implantation. One disadvantage of this type includes the possibility of competitive pacing when normally conducted ventricular activity spontaneously occurs.⁷ The development of a parasystolic rhythm or ventricular fibrillation (pace spike on T wave) can occur. Although extensively employed originally, this type is less commonly used today because it sometimes proves physiologically unsound.

The synchronous (atrial-triggered) pacer is more complex and utilizes a unipolar sensing electrode placed in contact with the atrium for detection of the P wave with another unipolar driving electrode which is in contact with the ventricle. There is a rate limiting circuit which blocks ventricular responses in excess of 125 beats per minute for adults and 150 beats per minute in the special model for children. The pacer automatically delivers a fixed rate of 60 beats per minute in the event it does not sense the P wave or when the atrial rate drops below the preset value. Although this pacer was once only implanted employing the transthoracic approach suturing the electrodes to the epicardial surfaces, more recently a permanent pacer has been developed employing two electrode catheters which can be inserted transvenously. One of these is positioned in the

right atrium while the other is positioned in the right ventricle. This type pacer has only limited practicability today and is not widely used.

The R-triggered (standby) pacer has a similar circuit to that of an atrial synchronous type except that it requires only a single catheter electrode (unipolar) in contact with the ventricle. This electrode functions to sense the R wave and also to deliver the pacemaker pulse. When there is normal conduction with a rate greater than the preset minimal rate of the pacer, the pacer senses ventricular activity and discharges an impulse in fusion with each R wave. Therefore it does not compete with any naturally occurring conducted rhythm. During periods of heart block or during spontaneous ventricular rates lower than the preset rate, the pacer functions in a fixed mode discharging impulses at its preset value which is usually 70 beats per minute. The absolute refractory period of the pacer is 400 milliseconds limiting the upper rate to 150 beats per minute. When natural rhythms occur with rates above 150 beats per minute (exceeding the refractory period) a pacer block ensues resulting in impulses discharged on every other R wave. The Cordis Ectacor pacemaker is an example of this type.

The R-inhibited pacer (demand) also senses the R wave through the catheter positioned in the ventricle; but instead of discharging an impulse in fusion with sensed beats, the pacer is inhibited and remains quiescent. At rates below the preset rate of the pacer, it operates as a fixed unit discharging at its preset value. The Medtronic demand pacemaker is an example of this type which is most frequently used in the United States today and which has mainly been used in Alaska.

Some of the indications for permanent pacing include:¹⁴

- 1.) Acquired complete heart block whether or not symptomatic.
- 2.) Symptomatic congenital heart block.
- 3.) Symptomatic chronic bradyarrhythmias.
 - a. Sinus bradycardia, arrest or standstill⁸
 - b. Slow nodal rhythm
 - c. Atrial fibrillation with high degree A-V block
- 4.) Symptomatic partial heart block⁹
- 5.) Persistent tachyarrhythmias.
 - a. Supraventricular.^{10, 18}
 - b. Ventricular^{11, 12, 13}

Temporary pacing has also been widely employed since currently available drugs do not always afford adequate relief of cardiac arrhythmias. Pacing has been employed in the treatment of both atrial and ventricular arrhythmias.

Atrial stimulation has been used for treatment of atrial tachycardia, atrial flutter,¹⁵ A-V junctional

rhythm,¹⁶ A-V interference dissociation, reciprocal tachycardias,¹⁷ ventricular tachycardia and recurrent ventricular fibrillation.^{19,20} Ventricular pacing has been used for recurrent tachyarrhythmias and for problems complicating acute myocardial infarction.²¹ Some of the indications for cardiac pacing in acute myocardial infarctions are:

- 1.) Frequent PVCs in the presence of any degree of heart block.
- 2.) Advancing second degree heart block.
- 3.) All second degree heart blocks resulting from anterior infarction and bundle branch block.
- 4.) Complete heart block.
- 5.) Sinus bradycardia unresponsive to drugs.
- 6.) Recurrent ventricular fibrillation.
- 7.) To overdrive other persistent arrhythmias.

Certainly the subject of pacemakers is very broad and complex. The information presented in this article is but a minute sampling of the available subject matter. Such things as pacemaker electronics, insertion techniques, recognition of complications and numerous other pertinent parameters were not even mentioned. These subjects will afford further information for future articles.

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EXPERIENCE WITH PERMANENT CARDIAC PACEMAKERS IN ALASKA

By Frederick R. Hood, Jr., M.D.

Anchorage

Since 1967, the author has implanted permanent cardiac pacemakers in twenty-five patients in Alaska. Nineteen of these have been in the Native population, while the remaining six have been in Caucasians.

In the Native series, the indication has been that of symptomatic, complete heart block in all but one patient. In that individual, a 2:1 block was present, associated with repeated episodes of Stokes-Adams attacks. The average age at the time of implantation was seventy years; the majority have been Eskimo (15 of 19).

In the non-native patients, the average age has been 64 years. Only one patient has had a history of recent infarction with subsequent development of A-V dissociation. The remainder have had known complete heart block of two or more years duration with associated symptoms of congestive failure or Stokes-Adams attacks, or both.

In addition, many patients in both series demonstrated other manifestations of reduced cardiac output secondary to A-V dissociation, such as prerenal azotemia or symptoms secondary to poor cerebral perfusion, i.e., lethargy and forgetfulness, etc.

Additional indications for permanent cardiac pacing are other bradyarrhythmias such as partial heart block (2:1 or 3:1 block) or an intermittent block, wherein the patient will have periods of conducted supraventricular rhythm alternating with complete A-V dissociation. Chronic sinus arrest or sinoatrial block may also be indication for permanent pacing.

Untreated symptomatic complete heart block carries with it a high mortality; in untreated patients and patients treated with drugs but who did not receive permanent cardiac pacemakers, average overall one year mortality rates of forty to fifty percent have been reported. In patients receiving permanent cardiac pacemakers, other series have reported one year mortality rates of ten to twenty percent. Of these deaths, only a very small proportion appear to have been due to pacemaker complications or failure.

Transvenous placement of bipolar electrode in the apex of the right ventricle using the right cephalic vein was employed in all except one patient in this series. In that individual, the

external jugular vein was used when the cephalic vein was found to be too small to permit passage of the electrode. A fixed rate pulse generator was used in the early part of the series. However, several patients who previously had been in long standing complete block subsequently reverted to a partial block with intermittent conducted beats, resulting in pacemaker-induced extrasystole and parasystole. Though the likelihood of pacemaker-induced ventricular fibrillation due to stimulation in parasystole is small, it is now our routine practice to use a demand unit initially. Those patients who remain in complete heart block will have a fixed rate unit substituted at the time of routine pulse generator change at two years.

Five patients had developed intermittent pacing due to loss of electrode position. This has usually become evident in the first forty-eight hours, though one patient continued to pace for one week before losing capture. Three of these patients have done well after repositioning the electrode. Pacemaker capture was never complete in one patient and, because of this and recurrent arrhythmias, the unit was removed. That patient subsequently declined to have an epicardial electrode implanted. The fifth patient could not be maintained in capture despite repeated attempts to obtain a stable electrode position. The transvenous unit was then removed and epicardial electrodes were implanted by thoracotomy. Approximately one month later, that patient developed an occasional competing rhythm, necessitating replacement of the fixed rate unit with a demand unit. In the ensuing eighteen months, she has had no further problem.

Once capture had been obtained and maintained over a period of one week, none of the patients in the series experienced any problems as a result of electrode malposition.

Other complications have been few. In two patients, hematomas have developed in the pectoral pocket, necessitating re-exploration and evacuation of clot. Both have done well following this. None in the series have experienced any infections. One patient experienced early pulse generator failure; this was characterized by complete absence of pulse generator activity of abrupt onset. This individual had had long standing

complete heart block prior to implantation and, with the failure, had some return of his previous symptoms of dyspnea and light headedness. Satisfactory pacing was resumed after the pulse generator unit was replaced.

Broken electrode wires have not been a problem with transvenous units. One individual who had an epicardial unit implanted elsewhere has had electrode breaks on two occasions. On both occasions, the breaks occurred at the point the electrode crossed the costal margin and were incurred as a result of a direct blow to the area. The pulse generator implanted in an abdominal pocket was subsequently removed, leaving the epicardial electrodes in place, and a transvenous unit was implanted as previously described. He has since done well.

Though the manufacture of pulse generators is subject to strict quality control, the number of components, the intricate circuitry and the battery depletion produce an expected increase in failure rate after an interval of thirty months from the time of implantation. In view of this, it has been standard policy to have the patient return in two years after an initial implantation for routine pulse generator change.

The Native patients present an additional problem of followup due to the fact that many came from and returned to remote villages, accessible only by bush plane. These individuals have been instructed to record their pulses daily and to send rates recorded on the first three days of every month to Alaska Native Medical Center. They were also asked to notify the hospital if their pulse varied by more than six beats per minute or if they became symptomatic. In those cases where language barriers or old age precluded satisfactory record keeping, village aides were given this responsibility. In addition, periodic field and clinic visits were made by PHS Unit Hospital personnel and their findings were reviewed by the staff of ANMC.

The non-Native patients have continued to be followed by their private physicians and, in addition, are seen annually for evaluation of pulse generator status. No immediate or late mortality has occurred and all twenty four patients with permanent pacemakers are alive and pacing satisfactorily.

All have been symptomatically improved in that their Stokes-Adams attacks have been

terminated and the associated congestive failure has been relieved. In many instances, the patients have become more alert and have been able to return to pre-block levels of activity. Most have shown some decrease in heart size by x-ray.

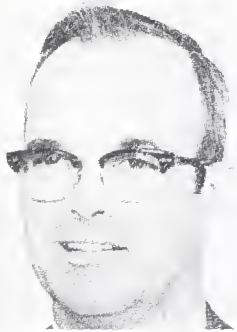
As a result of this experience, it is felt that the use of permanently implanted cardiac pacemakers should be encouraged for patients with symptomatic complete heart block, regardless of the rural aspect. Furthermore, recent reports suggest that the indications for use of permanent implantable pacemakers may be extended to include asymptomatic patients with complete heart block as well as symptomatic patients with lesser degrees of block.

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ADDENDUM:

Since submission of this paper notice has been received that one patient in the series has expired. That individual, a 78 year old Eskimo female, died in her village having previously been hospitalized for a cerebral vascular accident. No abnormality of pacing had been noted on that admission. Death occurred one year and one week after implantation and is presumed to have occurred as a result of extension of her cerebral vascular disease. In addition, the one patient in whom satisfactory capture could not be maintained, has since returned to the hospital with continuing severe Stokes-Adams attacks. A high output transvenous unit was implanted with satisfactory capture which has been maintained to the present.



OBSTRUCTION OF THE DUODENUM BY INTRAMURAL HEMATOMA

By James A. Wilson, M.D., F.A.C.S.

Ketchikan

While single case reports may well be of little significance, the report of an unusual and interesting problem case would seem to be the exception.

On March 6, 1969, an 18 year old white carpenter was admitted to the Ketchikan General Hospital following a car accident in which he sustained blunt abdominal trauma from the steering wheel. When seen in the emergency room, he was co-operative but acutely uncomfortable, pale and complained bitterly of pain in the right side of the abdomen.

His blood pressure was 120/80, pulse 78 and regular. There was marked tenderness on palpation of the right upper and right lower quadrants, but this was thought mostly to be in the abdominal wall. Hypoactive bowel tones were heard. Deep tenderness was present in the right flank.

Urinalysis revealed microhematuria. An admission pyelogram was interpreted as normal. Lumbar spine and abdominal x-rays showed no evidence of fracture, dislocation, free air, alteration of kidney shadows, or loss of psoas muscle outline. Serial Amylases, white counts and differentials and transaminase were within normal limits.

He was managed symptomatically and did well. At the time of his hospital discharge on March 10 his abdomen was soft, the tenderness in the abdominal muscle was pretty well gone, normal bowel tones were present, and he was eating satisfactorily.

On the day after discharge he noted onset of acute upper abdominal pain, and vomited for the first time. The following morning, Upper GI films showed complete obstruction of the third part of the duodenum with a sharp cutoff and pressure deformity. The patient was readmitted to the hospital with the diagnosis of a hematoma of the wall of the duodenum with obstruction. At exploration that evening, a four inch diameter hematoma of the third and fourth parts of the duodenum extending into the mesentery and down to the upper part of the right kidney was found. Mobilization of the duodenum by the Kocher maneuver allowed for exposure and the serosa and the longitudinal fibers of the duodenal muscle were split in an attempt to decompress the bowel wall. The hematoma proved diffuse and firm, not liquified, and no significant decompression was obtained. The hematoma extended to the left of the midline for at least two inches encompassing the superior mesenteric artery and vein. Some lesser bruising was evident on the serosa surface of the colon in the right upper quadrant. Since the duodenum could not be decompressed in the expected fashion, an anterior gastrojejunostomy was constructed. This was placed on the lower aspect of the greater curve approximately 2-1/2 or 3 inches from the pyloric sphincter. A double catheter jejunostomy was then constructed by using a 24 French catheter, with one of the catheters brought back through the anastomosis to act as a decompressive gastrojejunostomy and the other was to be used as a feeding jejunostomy, if needed.

Post operatively, the patient had a somewhat protracted course, characterized by failure of the gastrojejunostomy to function well. At the time of his discharge on March 22, 1969, the patient had been fed for four days through the feeding jejunostomy. His stoma appeared to be opening up and he was permitted to leave our area to report to his own surgeon in Coos Bay, Oregon. The rest of this report is due to the kindness of Doctor Pennington of that city.

Following his return to Oregon, he continued to have obstructive symptoms and finally was reoperated upon (April 1, 1969) and found to have an obstruction of the distal loop of the gastroenterostomy by inflammatory adhesions. These were freed and the enterostomies were resected. At the time of this surgery on April 1, 1969, the mass in the duodenal area was examined and found to be still swollen and hard. Following this second procedure, the patient made a rapid recovery and over the next six weeks, gained his weight back and except for the presence of three or four bowel movements a day, had no other problems. X-ray reports on April 1, prior to the second surgery showed a complete obstruction of the transverse portion of the duodenal loop. A second GI series done on June 30, 1969, showed that the gastrojejunostomy was functioning well but no barium appeared to be entering the duodenum. Serial radiographs taken over a period of 1-1/2 hours showed a small amount of barium in the duodenum cap. A repeat evaluation four months after injury showed him to be completely recovered clinically, and a GI study at that time showed no dilation of the proximal duodenal segment.

A review of current surgical literature shows that most cases of intramural hematoma of the duodenum have occurred in children. Apparently, in children, this lesion can usually be treated by simple incision of the serosa and evacuation of the hematoma. This appears to give an excellent result without complication. Rowe advises¹¹ against leaving a penrose drain in contact with the hematoma, as in one case, this appeared to cause a shelf deformity that led to a later obstruction.

Several cases of progressive dilation of the first part of the duodenum have occurred after a gastroenterostomy was performed without a concomitant pyloroplasty. Mathison⁶ and Morgan report one case where the duodenum was closed just distal to the ampulla after resecting the third part of the duodenum and performing a gastrojejunostomy. Several months later, the child was not doing well and a GI series showed marked dilation of the duodenal stump. The same authors caution against resecting the duodenum because of the gross appearance alone, as in their case, the

pathologist demonstrated an intact and presumably viable segment of bowel. They suggest that a serosal jejunal patch technique could be used to reinforce questionable areas of the duodenum, after evacuation of the hematoma. Other authors have used the injection of Methylene blue through a Levin tube to prove the integrity of the intact duodenal mucosal wall.

In our case, several interesting variations of this disease process are noted. The first and most striking was the failure of the duodenal hematoma to decompress at the time of surgery. There simply was no liquified blood present in the wall of the duodenum. An anterior gastrojejunostomy was performed because of the extension of the hematoma across the midline, and fear that the expanding hematoma could obstruct a posterior gastroenterostomy. Feeding and decompression jejunostomies were used and may have contributed to the inflammatory obstruction of the descending jejunal segment that necessitated the second operative procedure. At the time of the second operation, one month after the initial exploration, the duodenum on palpation was a hard firm mass.

In light of the GI series almost four months later it seems that this patient has gone on to develop a obliterative cicatricial process in the duodenum.

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MUKTUK MORSELS

FAIRBANKS

Philip Hardie, M. D., former Commander of Bassett Army Hospital, has retired from the military and joined The Fairbanks Clinic in General Practice. In 1969 Dr. Hardie and the Bassett Army Hospital Staff were co-recipients of the Alaska Medical Association's Physician-Of-The-Year award for their extraordinary support services during the Fairbanks flood. Speaking of floods, there has been an extremely deep snowfall in the Fairbanks area for this time of year and we understand that residents cannot decide whether to build levees or an Ark. We will all hope for a long slow spring melt.

Dr. Nicholas P. Deeley is the incoming President of the Fairbanks Medical Society.

Clinics for the diagnosis and evaluation of birth defects and for genetic counselling are being conducted by **Dr. Jon Aase** of Anchorage and **Dr. Dick Lyons** of Fairbanks on a monthly basis at various areas around the State. Clinics have already been held in Fairbanks and Anchorage, and future clinics are scheduled for these two cities as well as for Sitka, Kodiak, and other outlying areas of the State.

HOMER

Dr. Paul Eneboe reports that a patient raced into his office recently to have his "castor oil checked." When asked, "Your castor oil?" he said, "Yes, and might as well get an electricgram to be sure my arteries stay hard." **Dr. Eneboe** is the incoming President of the Kenai Medical Society.

ANCHORAGE

Dr. Elizabeth Hatton of Massachusetts has joined the Anchorage Pediatric Group. **Dr. Hatton** is Board Certified in Pediatrics.

Dr. Kenneth Behymer, a Board Eligible Internist most recently with the USPHS in Anchorage, has opened his private medical office in the Lake Otis Building.

Dr. Paul Sayer, a Board Certified General Surgeon, also newly out of the USPHS in Anchorage, has opened his private medical office at the Lake Otis Building.

Dr. Burl C. Stephens has taken over the Radiology Department at the Alaska Clinic. **Dr. Stephens** was formerly at the Providence Hospital in Anchorage, and follows **Dr. James Coin** and **Dr. John Gibbons** who have left the Alaska Clinic.

Dr. Stanley Austin, who has his Diploma of Anesthetics from The Royal College of Surgeons, has entered the solo private practice of Anesthesiology at the Anchorage Community Hospital.

Dr. William Bugh has closed his practice here at the Lake Otis Clinic, Inc. His future plans are indefinite.

Dr. Myron L. McCumber, formerly in General Practice in Orofino, Idaho, has joined the Lake Otis Clinic, Inc. (in affiliation with **Dr. Michael Beirne**) as Medical Director. He is currently also the sole physician employee of this group.

Dr. Augustin K. Gombart left the Anchorage Clinic to open a solo office in General Practice at the Medical Arts Building.

Dr. Glen B. Crawford was appointed to the State Medical Board for a four year term in October by then Governor **Keith Miller**. He joins **Dr. Henry Akiyama** of Juneau, President; **Dr. James A. Wilson** of Ketchikan, Secretary; **Dr. Charles F. St. John** of Anchorage and **Dr. James A. Lundquist** of Fairbanks. Their Board terms expire in 1971, 1972, 1974 and 1973 respectively.

Dr. Crawford also finally opened the magnificent new 100 bed **Glenmore** convalescent facility, designed to serve as a halfway house, providing hospital services on a sub-acute and chronic basis at a much reduced cost. The **Glenmore** has already taken much pressure off the very limited acute-care beds of Anchorage. In the planning stage now for years, the story of the many trials of construction alone are legion. Only the most hard-hearted could avoid a moist eye when news came through last year that a barge had overturned near Yakutat, sending all of **Dr. Crawford's** prestressed beams to the bottom of the Pacific, as well as delaying the long awaited grand opening for many months.

Dr. Frederick Hood is the new President of the Anchorage Medical Society.

Dr. Herbert James married **Mary Nelson** of Anchorage.

Dr. Frank Nicholas had a new son.

The Anchorage Medical Wives Group was recently recognized by the Alaska Mental Health Association for its positive approach toward better community mental health as demonstrated by their third annual "Women's Worry Clinic", designed to ventilate common female problems before the experts who deal with them constantly.

SKAGWAY

Dr. Joseph O. Rude continues to emerge from his active retirement bi-monthly to hold medical

clinics here. His son Dr. Donald Rude, who plans to return to his African practice in July, managed to join his father in a successful deer hunt during a locum tenens in Juneau.

JUNEAU

Dr. John A. Banholzer of Ohio, a Board Eligible Ophthalmologist, has entered private practice here, after a tour in the Navy.

Dr. Robert Cavitt is the incoming President of the Juneau Medical Society.

KETCHIKAN

Dr. Ralph Carr reports that daughter Susan has graduated from college and is enrolled in nursing school at the Cornell Medical Center in New York City.

WRANGELL

Dr. Harriet Jackson Schirmer reports that she is happy to be back in practice in Alaska. A former Service Unit Director at the PHS Hospital in Bethel, Dr. Jackson stayed in Bethel in private practice although prohibited by law from use of the hospital facilities. She later became married in Bethel.

Dr. Jackson Schirmer is the only physician ever to practice medicine privately in Bethel. Beloved by all her patients, her top-quality medical care is still the standard against which all new PHS physicians are measured.

QUEBEC

Keep an eye on the death of medicine here. All it took was a medicare decision to reduce specialists' fees to 65%, and Martial Law, under which the Premier of Quebec issued regulations that (1) any doctor not back at work within two days would be fined \$500.00 per day, (2) six months in jail for non-cooperative activities such as **trying to leave the Province!** (3) confiscation of private property of any who left successfully.

Let's see, at 65% of former income, in some fields of medicine the income would almost equal the overhead.

See McGill Medical School? Watch it die. See the doctors run.

Who will take care of Dick and Jane in Quebec? Maybe the politicians? Maybe the doctors in the jailhouse? Run, Doctor, Run!

Some of the details of this Quebec situation are incredible to those of us accustomed to thinking of Canada as our great democratic

neighbor to the east. Incidentally, the instigators of this great medical repression appear to be the labor unions.

Quebec Province regulations prohibit any citizen from carrying additional health insurance. The official Quebec Medicare scheme, for example, allows \$60.00 total for complete prenatal, obstetrical and postpartum care, or \$200.00 to \$300.00 total for the most complex heart surgery. The Medicare regulations provide criminal penalties for any attempt to carry extra health insurance, even for use only when traveling outside of the Province. They provide for criminal prosecution and loss of medical license if any physician is caught accepting money from a patient for care. In fact, secret government agents often visit medical offices posing as patients, and attempt to incriminate their physician by offering them money.

As of January 15th the War Crimes Act or Martial Law has been revoked or lifted. However, those several hundred persons (non-persons, actually) that were imprisoned without legal recourse during this period, can continue to rest easy in jail, knowing that they will stay there as long as the government so wills it, and that they will eventually be tried, at government convenience, under the War Measures Act. Military "justice", that is. Those crimes committed by the imprisoned fall into a general category known as "treason". Among the prisoners are newspaper editors whose crime was printing the FLN Manifesto, certainly a capital crime!

It may also be of interest to physicians generally that the Quebec government has taken over the routine yearly relicensing of physicians, and that medical licenses are now only reissued for specific counties. Thus, when the government deems a physician of a certain specialty unnecessary, they merely cancel his license for his current practice location, and validate it only for the county in which they have decided he should practice.

Many Canadian physicians, who thought such regulations unbelievable and impossible, were rudely awakened by the rumble of tanks past their homes, by the soldiers in the streets with machine guns, and by the armed border guards that turned them back, on their automobile ride near the border. Not the border of the country, the border of the Province! (maple leaf curtain?)

They had felt that such regulations could not be enforced; that their patients would not stand for such treatment of "my doc". They were sadly mistaken. The people watched smugly while the "rich docs got what they had coming to them!" The outcry of the public at such a fascistic theft of freedoms from a highly respected professional class

was deafeningly inaudible. In fact it sounded suspiciously like a faint chuckle.

The chuckle is beginning to come from the other side of the mouth, however. Over 40 of the 200 man clinical staff of McGill Medical School have already left for good, with most of the rest soon to follow. Those overworked docs still remaining can clearly remember the support their patients gave them in their time of need, and

somehow they can not be easily reached by their patients at night or when off-call. One gets a definite "The hell with you, too!" feeling that bodes ill for the ill of Quebec. You get what you pay for. Quebec citizens wish to pay only for minimal, impersonal, even inept medical care. One believes that they will shortly be lucky to get even this.

OUR EXPANDING PARAMEDICAL SERVICES - PART I

It is time to speak plainly, to simply identify the diagnosis, to prescribe treatment without beating about the bush, and once diagnosis and treatment are clear, to rely more heavily on paramedical personnel to carry out routine evaluations and completion of care.

A significant portion of the practicing physician's time is taken up by the female suffering from "middle years syndrome". This patient, often attractive but fading and frequently unhappily married, commonly enters with persistent, vague, nocturnal complaints of non-specific chest wall, epigastric, low back, suprapubic and inner thigh discomfort. Medical science has failed miserably in all attempts to alleviate these complaints with tranquilizers, sedatives, psychotherapy, diathermy, manipulation, hormones, hysterectomies, ultrasound, whirlpool, massage, or heating pads. Recently, however, a prominent Park Avenue specialist has reported on a small successfully treated series of these cases, which he considers a classical deficiency syndrome. In his paper, delivered to the Alaska Psychosomatic Society, Dr. Solomon B. Leigh, alleged that this syndrome was just as preventable as scurvy, beri-beri, and goiter.

Dr. Leigh found, in a small series of carefully studied dowagers unresponsive to the more usual modes of treatment, that complete and long lasting relief of symptoms could be obtained by regular provision of a medically approved stud service. During his revolutionary presentation Dr. Leigh pointed out that such service should not be available as an over-the-counter item, but that he felt, with proper physician control, trained paramedical assistants could, with license, greatly reduce the drain on available physicians. Dr. Leigh reported that at present such services were illegal in most states and thus frequently supplied by non-inspected and dangerously untrained,

non-medical persons. He brought up the question of whether such treatments should be covered by insurance, especially for non-hospitalized patients, when indicated to avert more serious and expensive diseases requiring hospitalization. He suggested that enabling legislation would have to provide for licensing of such services, for proper age restrictions, and determine whether the husband or parents permission would be required, as well as for adequate medical guidelines and follow-up.

In Dr. Leigh's opinion there was no need to involve the husband, since the question of stud service was really one between physician and patient. He felt that unnecessary involvement of peripheral people such as the husband would only complicate the therapeutic situation.

Epidemiological studies reported by Dr. Leigh corroborated the fact that the refrigerator replacing the icebox, supermarket milk purchases, and female letter carriers have all contributed to or aggravated this deficiency disease by reducing contact with potential sources of in-home therapy. Dr. Leigh suggested that initially, until confidence in the method was established, a committee composed of a clergyman, a physician, and a layman could be involved in the decision to proceed with such a program.

After some vigorous discussion of Dr. Leigh's methods and presentation, the Society referred the matter to the Health and Welfare Committee as a whole, which plans to proceed with an open mind on a larger statistically significant double blind study. Some panel members stated in open discussion that it was possible that Dr. Leigh's great interest in his new method might make it of greater therapeutic value in his hands, and that in any case his patient population was not typical. He was, however, accorded the brass ring and ball trophy for the most stimulating presentation.

ALL GOD'S CHILL'UN GOT 'SURANCE

By Elizabeth B. Fritz, R.N.

Anchorage

I have lived long enough to see the coming of age of medicine and its marriage to insurance. I have witnessed the romantic old-fashioned doctor-patient relationship. Now we are in a more commercial era and have a triangle caused by the third party, the insurance company, entering into the practice of medicine.

When this change first began, it was easy for the small staff to do a few insurance forms a month. However, the number increased and the paper work load began to interfere with the care of the patients. Something had to be done. We sent inquiries to the Mayo Clinic and the Mason Clinic who had had greater experience in dealing with this medical Paper Age. From their replies we were able to design our own form and from then on that is the only form which this office will use.

In this office we all enjoy caring for the sick. None of us are nor do we aspire to be insurance clerks. We have neither time nor interest to interpret insurance policies. We feel that any questions the patient has regarding coverage can be better answered by his insurance agent. Often it is difficult to make the patient understand that the doctor is not working for the insurance company, and though we honor his insurance plan, the patient himself is actually responsible for paying his medical bills.

The commercial forms which have been presented to us through the years have had questions numbering from seven on the simplest form to thirty-six on the most detailed. Most of these were not pertinent to the practice of ophthalmology and otolaryngology. Completing these unfamiliar forms was a time-consuming chore. These commercial forms had but one use and that was for submitting a claim to the insurance company. We felt that our form would not only do this but also serve two or three other purposes and all could be accomplished at one time. This saved duplicated or triplicated work. Before the copying-machine age, we were never supplied with enough copies of the commercial form to meet the needs of our office and the patients requirements.

It was embarrassing to execute and submit a form that had invariably been folded and refolded to fit a pocket or wallet, soiled from being carried

for days or had been decorated with coffee stains, marmalade, notes in the margins, phone numbers, even the grocery list, and on some occasions recipes. Even if the patient was not sensitive to this, we were.

Nothing is a greater anathema than having a would-be patient holding an insurance form ahead of him as he comes through the door saying, "This gets charged to Health and Welfare." or "The Doc's gotta sign here." Seldom is he concerned about his medical problem or the care he might be receiving. It is not "Health and Welfare" as we all know. What he means to say is that he is a beneficiary of an insurance plan, be it personal or through a group plan, in connection with his employment or union membership. Of course, the doctor does not "gotta" do anything but die. Very few patients realize that this is a task over and above his treatment and seldom do they say "please" or "would you mind."

Most of the forms submitted are blank as far as the section intended for the use of the patient is concerned and we ask that he complete it. For some this is the most difficult intellectual effort they have ever had to perform. There is no use telling the patient that we will not be completing his form for there would ensue a lengthy, time-wasting discussion. We simply accept his form and attach it to the original copy of our medical report form before sending it forward to the insurance company.

The simple four-part form designed by us in 1956 has been so satisfactory that it has not been revised. With the advent of the National Cash Register self-carbonizing paper, our form was modernized by using this stock in the same colors as previously used, eliminating the need for carbon paper.

When we suspect the patient will need an insurance form or as we choose to call it, a medical report form, we automatically have him sign the waiver of privileged communication paragraph on our form. This also can be used as an assignment of benefits. We place this form in a plastic cover on the front of the chart. There it cannot be overlooked or become buried in the IN basket. It is possible to add to this form each day that the patient is treated. As soon as the patient is

discharged, the form is completed, signed by the doctor that same day, and mailed or given out.

In separating the four pages, the bottom copy or blue sheet is placed in the patient's chart in front of all treatment to date. In this way we have retained a record of the information given out by this office and the date. If the bill has been paid in full, we give the original white copy and the pink and yellow carbon copies to the patient with the following slip attached. (see Fig. 1).

MILO H. FRITZ, M.D.

MEDICAL FACILITY:
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ANCHORAGE, ALASKA 99503
AMERICAN BOARD OF OPHTHALMOLOGY
AMERICAN BOARD OF OTOLARYNGOLOGY
AMERICAN COLLEGE OF SURGEONS
AMERICAN ACADEMY OF FACIAL PLASTIC
AND RECONSTRUCTIVE SURGERY, INC.

MAILING ADDRESS:
2235 VANDERBILT CIRCLE
ANCHORAGE, ALASKA 99504
AREA CODE 907
277-3612

Enclosed herewith are three copies of your receipted statement.

The WHITE copy is intended for commercial health and accident insurance representative. The insurance company will reimburse you for whatever portion of this fee that they allow. The check may be made out to both you and the doctor. If that is the case the doctor will be happy to endorse the check for you at any time that he is in the office.

The PINK copy is for your use in making out your income tax return.

The YELLOW copy is for your own files.

If additional copies are needed there will be a charge of five dollars per set.

Form 400-400-1M-4-69

(Fig. 1)

If the bill has not been paid and the patient has insurance coverage, we mail the original white copy to the insurance company. If the care has included surgery, a copy of the operative and pathological reports are stapled to this form.

The pink and yellow copies are retained on the chart in the accounts receivable file until the bill is paid in full and then they are mailed to the patient with the following slip attached. (see Fig. 2).

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2235 VANDERBILT CIRCLE
ANCHORAGE, ALASKA 99504
AREA CODE 907
277-3612

Here are two copies of your receipted statement.

The original white copy was sent to your insurance company at the time the service was rendered.

The PINK copy is for your use in making out your income tax return.

The YELLOW copy is for your own files.

If additional copies are needed there will be a charge of five dollars per set.

FORM 400-400-300-6-70

(Fig. 2)

Forms intended for the insurance company for handling a claim are mailed directly. We are very reluctant to give them to the patient to forward to his insurance carrier for three reasons. (1) Inevitably, there will be unnecessary delays in forwarding. (2) misinterpretation of the operative or pathological reports. (3) Removal of the operative or pathological reports necessitating the insurance company writing and asking if we had forgotten to include them.

Early every spring we receive many requests from patients for duplicates of the receipts that we have given them for treatment the previous year and which they have misplaced. The pink page of our form is for the patient's use in filling out his income tax form. It can also be misplaced but since it is larger and has more information on it than the small receipt, they are less likely to overlook it.

The last or yellow copy of the form is for the patient's own use should he move away or have occasion to visit another doctor. Thus they always have a record of what the findings were in this office and what was done for them.

Making these additional copies at the same time that we have executed an insurance form has saved us many hours of chart pulling, dictation, and transcription.

One set of forms for each insurance company is prepared without additional charge to the patient. If they have need of an additional set of forms to replace a lost form, then we make a charge for the secretarial service.

For all beneficiaries of the Union insurance plans that cover in part or fully the cost of eyeglasses prescribed following comprehensive ophthalmological examinations including refractions, it is necessary to state whether the patient was wearing glasses prior to the examination and what prescription was ordered. We add this in a narrative paragraph to the lower portion of the form.

To all patients for whom surgery is recommended and at the time that the recommendation is made, we give a written estimate sheet which clearly states the name of the operative procedure, the type of anesthetic, probable length of hospitalization, anticipated period of convalescence, and the fee. (see Figs. 3 and 4).

There are times when it is necessary to insist that the fee be paid in advance, for example, facial plastic surgery and the use of radium applicators. When we give the patient the estimate sheet, we also give him the following slip. (see Fig. 5).

In order to prevent the surgical no-shows who inconvenience the hospital staff, other surgeons, and the anesthesiologists, we insist that the patient pay one-fourth of the surgical fee when scheduling any surgery. If not, then it must be paid prior to his being admitted to the hospital. (see Fig. 6).

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MAILING ADDRESS:
2235 VANDERBILT CIRCLE
ANCHORAGE, ALASKA 99504
AREA CODE 907
277-3612

Date January 14, 1971

Name of Patient DOE, Jr., John William #49,352
Recommended surgery 1. 632-12 Tonsillectomy and
2. adenoidectomy
3. _____

Type of anesthetic General

Estimated stay in the hospital two days.

Estimated time at home after hospitalization five days.

Fee for the surgery \$120.00. This amount includes the physical examination at the hospital prior to the surgery, the operation, all of the post operative visits. It does NOT include hospital, laboratory, anesthetic or photographic fees.

If you have insurance 25% of the surgery fee is to be paid when the surgery is scheduled. If you have no insurance then the full surgery fee must be paid at the time of scheduling. All plastic and cosmetic surgery must be paid for in full when it is scheduled.

I understand that it is my responsibility to furnish the doctor with signed insurance forms and to do so during his office hours and before being admitted to the hospital.

Patient or Parent

In order to help you plan fully for your surgery, I suggest that you take this to the business office at the hospital where they will be glad to fill in the following:

Hospital charges (approximate)
Room _____ days at \$ _____ per day \$ _____
Operating room _____
Anesthetic _____
Laboratory fee _____
Medicine _____
_____ signed

Form 1000-A2-1M Sets-4-69 PATIENT
Form 1000-A2-1M Sets-4-69 HOSPITAL SURGICAL SUPERVISOR
Form 1000-A2-1M Sets-4-69 HOSPITAL ADMITTING OFFICE
Form 1000-A2-1M Sets-4-69 PATIENT'S CHART COPY

(Fig. 3)

One great advantage that this office staff enjoys and that all other staffs might not enjoy is that our doctor writes up his charts each day using the standard nomenclature and code number. In this way it is easily possible for anyone in the office to promptly complete the forms. This is one of the factors that contributes to our having a minimum of difficulty in collecting accounts receivable.

Many times patients will apologize for not having an insurance form to bring with them. When they go to the union office or insurance agent to

MILO H. FRITZ, M.D.

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MAILING ADDRESS
2235 VANDERBILT CIRCLE
ANCHORAGE, ALASKA 99504
AREA CODE 907
277-3612

Date January 14, 1971

Name of Patient DOE, Jr., John William #49,352

Irradiation with Radium

Type of anesthetic local

The fee for this therapy is \$ 150.00. This includes the three

visits necessary to complete the irradiation therapy. Since this is an elective procedure, the full fee must be paid before the treatment is begun.

1000-A-3-500 Sets 5-69 PATIENT'S USE
1000-A-3-500 Sets 5-69 PATIENT'S CHART COPY
(Fig. 4)

obtain such a form, they are told it is not necessary if you are going to Dr. Fritz because he has his own form.

Our medical report form has been honored by all companies to whom it has been submitted with the exception of that insurance which covers United States Coast Guard dependents and the retired military personnel. We have encountered these two categories only when holding clinics in Southeastern Alaska.

The proper use of our simple but multiple-use form over these many years has made very light work of the otherwise onerous chore. We have never had any complaints from insurance companies and very seldom a question on clarification. If it is information that the insurance companies want, they have it all; and if it is forms that they want filled out, they are always at liberty to copy the information onto their form.

MILO H. FRITZ, M.D.

1027 FOURTH AVENUE
ANCHORAGE, ALASKA

AMERICAN BOARD OF OPHTHALMOLOGY
AMERICAN BOARD OF OTOLARYNGOLOGY

DIAL 33355

If you have Blue Cross or any other Health and Accident Insurance that covers your medical expenses we shall be very glad to supply you with three copies of your receipted statement one of which you may send to your insurance agent. In this way a refund will be made to you for whatever portion of the fee is allowed by them.

Form 500-500-3-26-57

Some members of the Alaska State Medical Association were making a great effort at one time to have the State medical Association adopt a standard insurance form, which would have been a good idea. However, the form selected would have only served one purpose and that would have been to submit a claim; and we feel that our way is better in that it has other uses and can all be accomplished at one time.

MILO H. FRITZ, M.D.

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MAILING ADDRESS: 2235 VANDERBILT CIRCLE ANCHORAGE, ALASKA 99504
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Master John William Doe, Jr. #49,352

YOUR OPERATION HAS BEEN SCHEDULED FOR

Friday, January 15, 1971 AT 8:00 a.m.

THIS WILL NECESSITATE YOUR BEING IN THE PROVIDENCE HOSPITAL NOT LATER THAN 2 00 P M

Thursday, January 14, 1971

PLEASE STOP IN DR FRITZ'S OFFICE BEFORE GOING TO THE HOSPITAL TO 1:00 p.m., Thurs., Jan. 14, 1971

1. SIGN THE SURGERY PERMIT.
2. LEAVE YOUR COMPLETED INSURANCE FORM.
3. IF NO INSURANCE, TO PAY THE SURGERY FEE

To fulfill a more recent requirement of the Internal Revenue Service, we are using a rubber stamp to affix the IRS identification number and the doctor's Social Security number. With the next printing of our form, we will have this information printed on it.

Color Art Printing at 430 Seventh Avenue, Anchorage, Alaska 99501 prints our form No. 9000 at the cost of fourteen cents per set if one thousand sets are ordered. We use them at the rate of ten or fourteen a day.

We have no insurance clerk and any one of the nurses, technicians, secretaries, or aides can complete these forms with the greatest of ease and in a remarkably short time.

AREA CODE 907
277-3612

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ANCHORAGE, ALASKA 99503

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MEDICAL REPORT

To: Blue Cross of Washington - Alaska Group No. 8432
P.O. Box 327 Policy No. 44-53-72
Seattle, Washington 98111 Clinic No. 49,352

Patient's Name: DOE, Jr., John William Age 10
Address: 1010 Updyke Lane, Anchorage, Alaska 99504

Name of Policy Holder: Mr. and Mrs. John William Doe, Sr. (Mary Ellen)

1. Diagnosis: (explain any complications)

632-100.6 Chronic hypertrophied tonsils and adenoids due to infection

2. Patient First Consulted Physician for This Illness on: January 14, 1971

3. What Operation Was Performed, If Any? 632-12 Tonsillectomy and adenoidectomy

4. Patient Was Confined to Providence Hospital From: January 14, 1971 To: January 16, 1971

5. Dates of Treatments: Office: January 14, 20, 1971

Dates of Treatments: Hospital: January 14, 15, 16, 1971

6. Estimated Date Patient Will Resume Employment: Partial: Full Time: January 21, 1971

Date: January 20, 1971 By: M.D.

I Hereby Authorize Milo H. Fritz, M.D., Anchorage, Alaska, to Furnish to the Above-Named Insurance Company All the Information Which Said Insurance Company May Request Concerning My Present Illness or Injury. I hereby authorize that benefits, otherwise payable to me, be paid as indicated below, but not to exceed the charges shown herein or on any statements attached. I understand I am financially responsible for charges not covered by this authorization. Medical and Surgical Benefits to Milo H. Fritz, M.D.

Date: January 14, 1971 Signed: John W. Doe, Jr.

STATEMENT OF ACCOUNT

January 14, 1971 - Ear, nose, and throat consultation \$ 10.00
January 14, 1971 - Admitted to the hospital, physical examination, and one hospital visit no charge
January 15, 1971 - Tonsillectomy and adenoidectomy, two hospital visits . . \$120.00
January 16, 1971 - One hospital visit and discharge no charge
January 20, 1971 - Post operative office visit no charge

Balance due \$130.00
Paid 40.00
Final balance due \$ 90.00

The Above Information Has Been Abstracted From the Patient's Medical Record.

By: M.D.

Form 9000-1M Sets-4-69

Form 9000-1M Sets-4-69

Form 9000-1M Sets-4-69

Form 9000-1M Sets-4-69

INSURANCE COMPANY COPY

FOR PATIENT'S USE

FOR INCOME TAX PURPOSES

REMAINS IN PATIENT'S CHART

Alaska Medicine



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JUN 10 1971

Volume 13, Number 2 April 1971

ANNUAL STATE CONVENTIONS DENTAL - HOMER, JUNE 7, 8, 9
MEDICAL - JUNEAU, JUNE 9, 10, 11

3

Polymyxin B—Bacitracin—Neomycin

against 10



Pseudomonas



Hemophilus



Klebsiella



Aerobacter



Escherichia



Proteus



Corynebacterium



Staphylococcus



Streptococcus



Pneumococcus

‘Neosporin’[®] Ointment Polymyxin B—Bacitracin—Neomycin

Overlapping, broad bactericidal coverage.

Nonirritant ointment base; also enhances spreading and penetration.

Each gram contains:

‘Aerosporin’[®]

brand Polymyxin B Sulfate 5,000 Units

Zinc Bacitracin 400 Units

Neomycin Sulfate 5 mg.

(equivalent to 3.5 mg. Neomycin Base)

Special White Petrolatum q.s.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the external ear canal if the eardrum is perforated.

Precautions: As with other antibiotic products,

prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Available: Tubes of 1 oz., 1/2 oz. with applicator tip, 1/8 oz. with ophthalmic tip. The ointment base and the formula of the various sizes are identical, but only the 1/8 oz. tube should be used for ophthalmic purposes.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

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ABOUT THIS ISSUE

This issue considers Alaskan health facilities and problems. As so often occurs, the reality is less than the plan. What has emerged is a modest over-view of Alaska's private and Public Health Service Hospitals with even briefer commentaries on the State Psychiatric and military hospitals and nursing homes. Little is said about the military, as they have a distinct and separate mission. Alaska's nursing homes failed to respond to our inquiries.

Where practical or willing the community hospitals tell their own stories. Hospital administrators repeatedly tell of poverty, low occupancy, ancient and malfunctioning equipment, and accreditation problems. To avoid duplication much of this material was deleted. I would therefore like to apologize to those who see their efforts somewhat abridged.

Dr. John Lee and Dr. Robert Fortune present two excellent views of the Public Health Service; one spanning the entire system and the other an in-depth study of how one part of the system evolved and developed.

Mrs. Anna Wenzel tells the other side of the accreditation story. She points out her problems and the difficulty of trying to stretch Alaska's hospitals into a system that was designed for vastly different circumstances.

And finally, the dowdy Banquo casts light upon some of the interactions occurring between the "systems" and the pitfalls of too much government medicine.

Many excellent ideas herein described have developed at The Bush Medicine and Public Health Committee meetings, at which Alaska State Medical Association members and others have contributed much time, effort, and thought to problem areas in the delivery of health care. — P.E.

LETTER TO THE EDITOR

Dear Sir:

A public warning has recently been issued concerning "baby bouncers" or "walker-jumpers" which are collapsible spring-supported infant seats. The FDA reports that these seats may be hazardous and have caused severe injuries to some babies including at least nine finger amputations. Lacerations and abrasions of the hands and face also have been reported. These occur when the child places a finger in a pivot on the spring area or when the unit accidentally tips or folds.

To determine if the product is safe, the Bureau of Products safety advises checking the following danger sites:

the hinge areas of reclining models may have holes through which the infant could insert a finger;

- X shaped pivotal areas may exert a scissors effect on a child's finger;
- unguarded coiled springs into which a finger may be inserted;
- lack of a locking device or safety ring to prevent accidental collapse when occupied;
- tendency to tip when a leg hits a floor crack, rug seam or other obstacle.

Sincerely yours,
Elizabeth Price, M.D.
Chief, Community Health Section

ROBERT H. SHULER, M.D.

1914 - 1971



Robert H. Shuler, M.D., 56, died of an apparent heart attack April 1, 1971 in Philadelphia.

Dr. Shuler was at the Hotel Sheridan in Philadelphia, attending a National School Board Association meeting along with other Sitka school board members. The group had arrived earlier in the day, having left Sitka Wednesday. That evening Dr. Shuler complained of not feeling well and had retired to his room, where he was found the next day.

Dr. Shuler was medical officer in charge at Mt. Edgecumbe Public Health Service Hospital 1949-51, and after private practice in Juneau from 1952-1956 returned to Sitka in private practice.

Dr. Shuler was born June 26, 1914, in Superior Nebraska, the son of Harry A. and Lillian Hall Shuler. His father was a railroad company employee.

Dr. Shuler received his bachelor's degree in 1935 from Hastings (Nebraska) College, his masters in parasitology from the University of Nebraska in 1937, and his Ph.D. in physiology and medical doctorate from the University of Chicago in 1941.

He did his internship and residency in internal medicine at King County Hospital in Seattle.

He taught, on a teaching fellowship, at the University of Nebraska 1935-1938, was associate professor of biology at Peru State Teachers College 1938-1939, had a teaching fellowship at the University of Chicago 1939-1941 and 1944-1945.

He was associate professor of physiology at the University of Georgia School of Medicine 1942-1943 and associate professor of biology from Roosevelt College, Chicago, in 1947.

He was TB consultant for the Alaska Department of Health 1953-58, and city health officer in Sitka from 1962 to the present.

He was a member of the Alaska Association of Schools (secretary-treasurer at the time of his death), National School Board Association, American Medical Association, American Academy of General Practice, Association of State Medical Society Presidents, American and Alaska Public Health Associations.

He was past president of the State Medical Association and Toastmasters, Inc.

He belonged to the Elks, American Legion and Order of the Moose, and had been a member of the school board for 10 years.

He was a member of the Army Medical Corps and was Lt. Cmdr. (ret.) in the U. S. Navy.

He belonged to the Unitarian Fellowship.

Survivors include his widow, Irene, of the home, children Mark, 17, and Barbara, 20, who live with their mother in Pacific Grove, California; a brother C. R. Shuler of Bakersfield, California, a sister Mrs. Rus Van Dyke, of Des Moines, Iowa, and his mother, Mrs. Lillian Shuler of Des Moines.

(from the Sitka Sentinel)

GRACE JANSEN HOEMAN, M.D.

1921-1971



Grace Jansen Hoeman, Anchorage anesthesiologist, died on April 12, 1971, in an avalanche on Eklutna Glacier near Anchorage. One companion was also killed; another escaped. Search parties found no trace of the two lost climbers.

Grace was born at Silver Beach, Washington, but lived much of her life in Holland and Germany. She gained a M.B. degree in 1944 from the University of Berlin, and her M.D. in 1948 from the University of Utrecht. In Berlin she trained in surgery, gynecology, and obstetrics, but when she returned to the United States in 1950 she took a

staff position at an upstate New York tuberculosis hospital, then won a master of public health degree at Yale (1953). For several years she taught preventive medicine at Buffalo before entering anesthesiology residency at Syracuse Hospital Upstate Medical Center (1960-62). She remained on the staff at Syracuse as assistant professor of anesthesiology until coming to Alaska in 1965. She was fluent in German, Dutch and French and spoke English without an accent. She wrote articles about infectious disease and anesthetic agents.

In her twenties she survived diphtheritic myocarditis and two bouts of tuberculosis. Later migraine, anemia, acute mountain sickness, and thrombophlebitis hampered but rarely defeated her intense mountaineering efforts. Her first husband was killed in World War II. Two daughters survive. A second marriage ended in divorce. Her third husband was famous young Alaska naturalist-geographer-climber Vin Hoeman. He was killed in an avalanche on Dhaulagiri in Nepal almost exactly two years before Grace met a not unwanted similar death.

The passion of Grace's life was mountains. In Alaska she was more active in mountaineering than in anesthesiology. She climbed and described innumerable Alaska peaks, climbing many of them recklessly alone after Vin's death. She stood on Mt. McKinley in June, 1970, after several previous failures. At the time of her death she was compiling the voluminous writings of her beloved Vin for the American Alpine Club and had nearly completed her own guide to the Western Chugach Mountains.

Grace was aggressive; Grace was sometimes abrasive. Her sense of right and wrong was peculiarly hypertrophied. She fought battles which did not need fighting. But she knew serenity; she knew beauty; she knew love. She was an unusual and extraordinarily gifted person.

ALASKA'S SMALL HOSPITALS

Reading about Alaska and Alaskan problems one encounters the words vast, remote, distance, isolation, transportation, communication, weather, sparse, scattered, geography and climate ad nauseam, but no other words can describe the Alaska "thing" and these words give Alaska its uniqueness. Like everything else in Alaska our hospital system is unique. In no other state is such a major segment of the health care delivered by federal or government physicians. And in no other state does the federal government have such a proportionally extensive hospital system. Alaska has not one but two huge government hospital and health delivery systems. Either one alone would be significant but combined they dominate and overshadow the Alaska health delivery system. For good or evil they are a part of Alaska's landscape, and any planning or consideration of Alaska's health problems must take them into account.

Taking two criteria, that of physicians and hospital beds, the dominance of the federal government becomes readily apparent. Today in Alaska there are 177 private physicians. There are 184 physicians in the employ of the United States government, 110 of these in the United States military and 74 in the Alaska Native Health Service. Hospital beds show the same; there are 702 private hospital beds in Alaska. There are 1,146 government beds, 593 in the military and 553 in the Alaska Native Health Service system. Adding to this 390 State Hospital psychiatric beds, and 308 State Hospital chronic care beds, completes the picture of one aspect of Alaska's health resources. The average capacity of our community hospitals is 28 beds, if Providence Hospital in Anchorage is excluded.

In this issue of *Alaska Medicine* we point out some of the contrasts between the giant government systems and the disorganized, dis-giant, occasionally inadequate, civilian, non-native hospital system, i.e. Alaska's community hospitals. We will describe what has been accomplished and hope to stimulate the search for ways to improve our community hospital "system".

In Anchorage, both Providence and Community Hospital Services have grown rapidly, Kodiak has a new hospital, Juneau, Fairbanks and Soldotna all have new hospitals in the final stages of construction. Yet the picture does remain grim for the small hospital. And the smaller the hospital, generally speaking, the grimmer the picture. It can be argued that the small hospitals are unnecessary, that they are inefficient, inadequate and their contribution to medical care insignificant. But to those people living in the community, the hospitals

are indispensable. Here indeed do the words remoteness, isolation, transportation and weather become important. These hospitals are vital to the communities they serve and as such must be supported. If a community warrants medical services and facilities, it warrants good medical services and facilities. Pinched between the rising need and demand for new services, rising operating costs and obsolete facilities, few of Alaska's smaller hospitals can remain adequate let alone "good". Our hospitals can be criticized for being "physicians' workshops", but critics notwithstanding, the physician is still the central figure in any health delivery system, and the day is gone forever when a physician can practice competent medicine out of a black bag. He needs a two story building and about twenty assistants. He is more an executive director than an individual technician, and a hospital is more than a building full of equipment, it includes a number of highly trained and expensive people.

A major reason for the small community hospitals remaining physicians' workshops and their not providing broader community services is that state and federal governments have ignored the small hospital and have not allowed community hospitals to develop a base of broad services. The federal government, through its military, veterans and Alaska Native Health Service organizations, has steadfastly refused to utilize the small community hospital except in cases of dire necessity. In this aspect the military is certainly less important than the V. A. and ANHS, whose appropriate utilization of the small community hospital could have a significant positive impact on the hospitals' financial status. The state government for the most part has ignored the hospitals. Many of the State's health care programs which could be hospital based are not. Such programs as rehabilitation, mental health, public health nursing and TB control could well utilize community hospitals. By providing such services through a community hospital, the State could have had a significant impact on up-grading the hospitals' facilities and services. Even today, the State of Alaska will bring its own x-ray machine into a community rather than utilize that community's existing but under-used x-ray facilities.

In the larger communities the hospitals will continue to grow and function, albeit not without financial problems and occasional crisis. This may not be true of those under 20 to 25 beds. These generally are located in small, isolated communities with a marginal economic basis, such as Glennallen, Seward, Homer, Wrangell, Petersburg, Palmer,

Sitka or Nome. In these communities much help is needed, not just to maintain but to upgrade health facilities. In the past these communities have done it themselves, received assistance from churches, wealthy benefactors or local industries. These sources of income are becoming increasingly scarce and proportionately of less significance as operating costs soar. With decreasing availability of such funding, the state and federal government must begin to assume an increasing role. There is much that could be done to subsidize the small hospitals without a great change in the law. The Alaska Native Health Service could stop its practice of shipping patients to its own large hospitals and subsidize the small local hospitals by utilizing them. This same is true of the Veteran's Administration.

The State of Alaska has not recognized or met its responsibility to assist in the provision of health and medical services in rural communities. Last year's revenue sharing bill was a start but more is needed. Not only do most of our small hospitals need assistance with their operating expenses, but many are plagued with obsolete or absent equipment, and inadequate facilities that need remodeling or rebuilding. A construction grant or loan fund has been a desperate need.

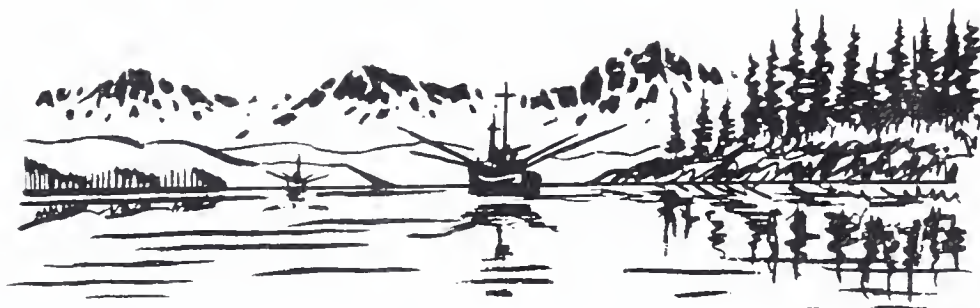
Medicare, too, has been hard on small hospitals. Its evaluation procedures need to be changed. To expect a small hospital with one or two physicians to run an out-patient department, or worse yet, to divide its single physician into twenty different department heads, each with quarterly reports, financial statements, and cost accounting surveys, is inappropriate. The Medicare practice of cost analysis can turn into a cruel disaster. Many times the administrators of the smaller hospital, who frequently double as head nurse, dietician or anesthetist, are unaware of the intricacies of the multiple rules and regulations regarding Medicare. The practice of paying at more than 100% of cost and then reauditing the books two years later and reducing the overpayment to

90% of cost, then expecting the hospital to cough up \$10,000 out of a \$50,000 or \$60,000 budget is incomprehensible. Yet this has happened. One hospital victim in Alaska is still trying to recover from such a low blow, which all but closed its doors.

The large federal hospitals in Alaska have a plethora of expertise in many areas. Dieticians, medical record librarians, sanitarians, administrators, financial experts or x-ray and laboratory technicians seem to abound. How wonderful it would be if some of their knowledge could be made available to those communities which could never afford them. There are existent in both the Public Health Service and the military hospitals many wonderful in-service training programs for their respective staffs. Little attempt has been made to make these training programs available to the rural hospitals of Alaska where the need is compounded.

Alaska's larger private hospitals too have a responsibility. As the recipient of many problem cases which smaller hospitals cannot handle, the large hospitals do frequently provide speciality backup and medical consultation. But would it not be feasible for the small hospitals to utilize the central supply services or the purchasing power of a large hospital to help meet their needs and cut their costs. The large private hospitals, too, have skills and resources available to them such as laboratory, x-ray or pharmacy. With some imagination and effort the larger hospitals could assist their poverty stricken brothers.

Numerically, perhaps, Alaska's small hospitals do not account for a large number of patients, but area-wide many of these hospitals cover an area larger than a moderate sized state "outside". Their small size and remote location cause them unique and difficult problems. With some imagination and effort on the part of those with resources, the burden of worry carried by the small hospital could be considerably lightened and the patient care and service role greatly expanded. — P.E.

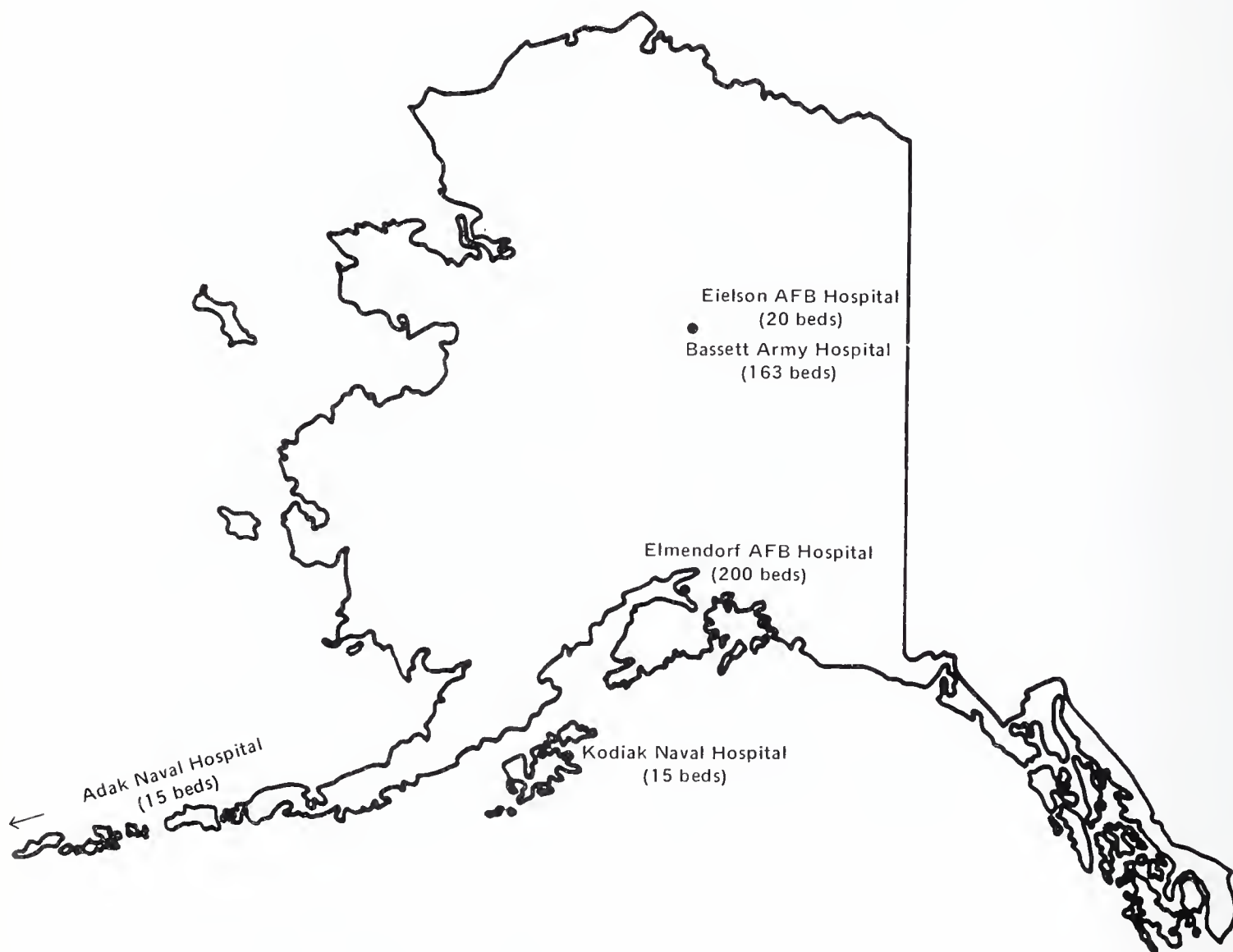


ALASKA HOSPITAL ROUNDUP

THE MILITARY

With limited and highly defined missions, the military hospitals in the state have little effect on the non-military population and its needs. Dominating the military hospital scene is the 200 bed general medical and surgical hospital at Elmendorf Air Force Base. The Army has its major hospital, Bassett Army Hospital located near

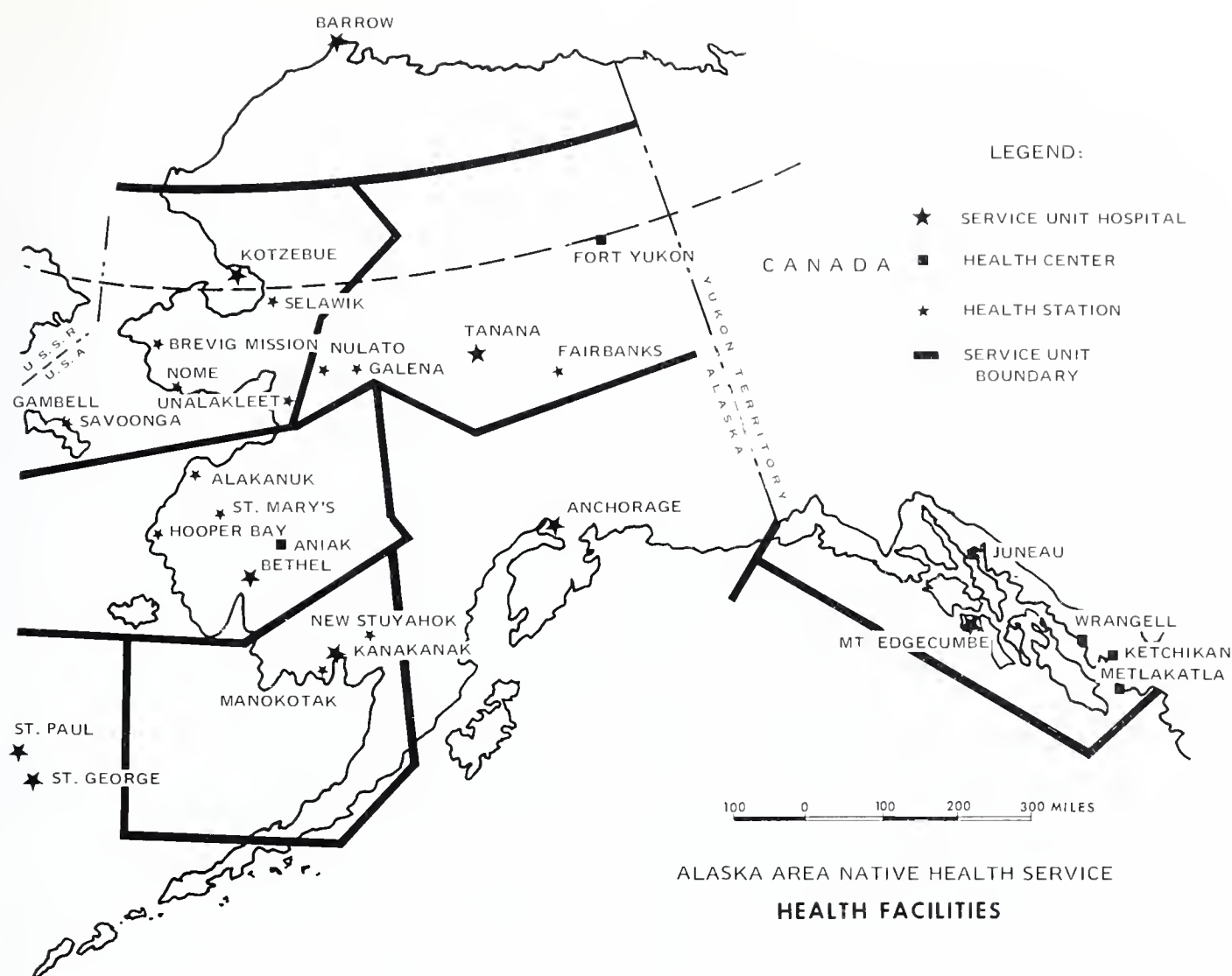
Fairbanks at Fort Wainwright, with 163 beds. These two major military hospitals are backed up by smaller facilities at the various military bases and by the two Naval hospitals at Adak and Kodiak, with 15 beds each. Besides the military and their dependents, the military hospitals provide care to veterans living in Alaska.



PUBLIC HEALTH SERVICE HOSPITAL SYSTEM

Dr. John Lee's article delineates the Public Health Service's extensive system which boasts of Alaska's largest hospital, the Alaska Native Medical Center, with 276 beds located in Anchorage. Dr. Robert Fortune's article develops in-depth the evolution and history of one segment of the Public Health Service system. The Anchorage facility is

the supporting and consulting center to the six service unit hospitals scattered throughout the state; Barrow, Bethel, Kanakanak, Kotzebue, Mt. Edgecumbe and Tanana. Besides these hospitals, the PHS system includes outlying health centers and stations staffed by physicians and nurses.



PRIVATE AND COMMUNITY SPONSORED HOSPITALS AND NURSING HOMES

Where appropriate or willing the private hospitals and nursing homes tell their own story.

SOUTHEASTERN ALASKA

Seattle oriented, the hospitals of Southeastern Alaska lie under the pale of the Public Health Service Hospital in Mt. Edgecumbe, which drains off significant numbers of patients and increases the problems of low occupancy.

KETCHIKAN

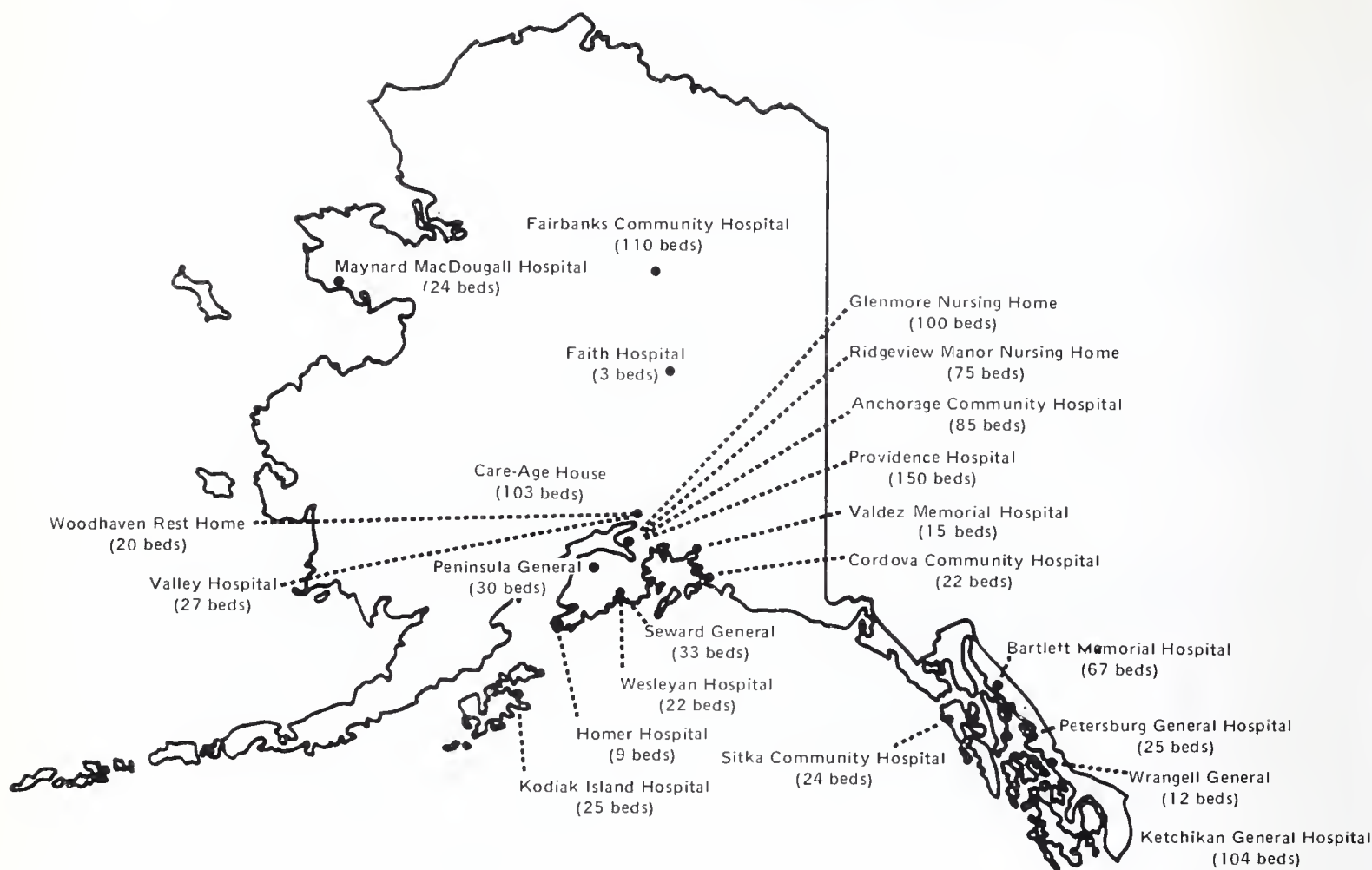
by
Sister Monica Heeran, Administrator
and
Pat Mahoney, Associate Administrator

Ketchikan General Hospital is a 55 bed, fully accredited, short term, general hospital serving the

people of Ketchikan and the surrounding communities, including the towns of Metlakatla, Craig, Hydaburg and Klawock. The total service area encompasses a population of some 13,000 people. Owned by the City of Ketchikan, the hospital is operated by the Sisters of St. Joseph of Newark. Completed in 1963, the new hospital is one of the four non-governmental accredited hospitals in Alaska.

Recognizing a community need for nursing home beds, the people of Ketchikan made it feasible to complete the new 40 bed long term care addition (Island View Manor) in 1968. Demand for this facility is so great that in only two years the nursing home has a 100% occupancy rate with a waiting list currently of some eight people. Island View Manor is a fully accredited nursing home.

In 1970, the hospital and medical staff, which includes nine general practitioners, a surgeon, an



internist, and a pediatrician, cooperated with the University of Washington Medical School in organizing an externship program for Ketchikan. Two senior medical students spent a total of six weeks elective as family practice externs. Both the students and the hospital's medical and nursing staffs found the experience to be educational. The hospital hopes to participate in an extension of this program in the near future.

Dedicated to the common goal of excellence in service to the patient are the 151 hospital employees. To keep abreast of changes in their various fields and to improve their various skills, many employees are involved in the continuing educational process. All supervisory personnel are participating in the hospital's newly instituted management development program.

The progress of updating hospital facilities and medical care in Southeast Alaskan communities has been fairly rapid. Fewer patients are being sent south. Gradually, the communities can afford the luxury of a few specialists.

One persistent problem, common to other General Hospitals, is a low occupancy rate,

although this has been improving during the past year. A contributory cause is the fact that many native patients from Ketchikan are sent to the Public Health Service Hospital at Mt. Edgecumbe, Alaska for hospitalization. This not only affects the hospital but has greater consequences to the native patient who must leave his family and doctor and travel a great distance to Mt. Edgecumbe. Ketchikan General Hospital now has the facilities and medical expertise to provide service for substantially all of the greater Ketchikan area residents. It is in the best interests of all concerned that the native patients be given a free choice as to whether they wish to be cared for in their local community hospital or in a Public Health Service facility. The fragmentation of patient care which is now practiced could be eliminated to a large degree, doctor expertise could be increased, and patient costs reduced, if Southeast Alaska community hospitals were more fully utilized by all of the residents of each community.

The Gateway Community Mental Health Center is another service that the hospital has been

able to utilize. Established only in February, 1970, out-patient treatment services include individual therapy, marital counseling, family and group therapy. The volume of out-patient work has provided a good alternative to admission to a mental hospital for patients with major mental illnesses. The psychiatrist-director, psychiatric nurse and the two psychiatric social workers travel to various communities in Southeast Alaska. The services rendered are out-patient care, consultation and education.

The people of Ketchikan, by their continued support and interest in the hospital and other health projects, are demonstrating a unique sensitivity to the health care needs of the community. The hospital, too, cognizant of its role as a community facility, is dedicated to the provision of high quality service. It is committed to participate actively in civic planning for health and medical care.

WRANGELL

by Emma G. Ivy, R.N. Administrator

The Wrangell Hospital is a new 16 bed general hospital owned and operated by the City of Wrangell, built two years ago with the aid of Hill-Burton financing.

Due to our small size we have been unable to attract coverage for our anesthesia or pharmacy and we are financially unable to employ someone full-time in these areas.

Until the arrival of Dr. Harriet Jackson Schirmer, Wrangell was covered by locum tenens physicians. These physicians were obtained through the aid of the Alaska State Medical Association and the Washington-Alaska Regional Medical Program. The length of coverage was for about two weeks. In less than a year we had 23 changes of locum tenens physicians at the Wrangell General Hospital.

PETERSBURG

Petersburg has a 25 bed general hospital and one physician. The hospital is owned and operated by the City of Petersburg.

SITKA

Sitka has a 24 bed community hospital, outdated and badly in need of expansion. A second facility is the 65 bed Alaska Pioneer's Home. Across the channel is the massive white elephant, the U. S. P.H.S. hospital at Mt. Edgecumbe. Sitka's four practicing physicians provide care to the non-native residents of the Sitka area.

JUNEAU

Juneau is just completing the new 67 bed Bartlett Memorial Hospital which will replace the historic St. Ann's Hospital of Juneau. The completed hospital will provide up-to-date facilities for Juneau's eleven physicians. Faced with the problems of anticipated low occupancy and under-utilization, Administrator Jack M. Scollard writes, "If we are to use our hospital facilities and professional, technical and paramedical personnel to the best advantage, every effort must be made to avoid duplication of facilities and to use physical plants and existing skills to the maximum advantage, regardless of the source of hospital ownership."

Mr. Scollard further points out a problem germane to almost all hospitals in Alaska, "with minor exceptions, paramedical staffing of health care facilities has depended on migration of professionals from the "lower 48". Because of small population, professional schools or paraprofessional schools have not been economically feasible. Therefore, educational opportunities for Alaska youth in health fields have been limited. An imaginative approach to training of personnel needs to be developed. By using existing facilities to the best advantage, both health and education training programs should be developed in such fields as medical record librarian, food service management, administrative management, x-ray technician, laboratory technician or nursing."

SKAGWAY

Skagway's not uncommon problem is that of a new five bed health center-hospital and no physician.

HAINES

Haines has no hospital but members of the Bush Medicine Committee who recently toured Haines were impressed with the very competent and common sense approach taken by Haines' physician, Dr. Stan Jones, who has constructed an office with a built-in delivery room and two beds, providing an excellent facility for his community.

SOUTHCENTRAL ALASKA

CORDOVA

by Homer C. Christensen

Situated in Prince William Sound, Cordova and Cordova Community Hospital provides medical coverage for patients, from Tatitlek to as far away as Cape Yakataga and Yakutat. Patients

come to Cordova by boat or plane since Cordova has no highway link with the "outside".

Once the booming capitol of copper, Cordova has declined to a community of a little over 1000. It is now the center of a bustling commercial fishing industry with three local canneries and others in the surrounding area. The summer influx of fishermen places an added strain on medical facilities.

The Cordova Community Hospital, a two floor, 22 bed hospital was constructed with local help, Hill-Burton funds and assistance from the American Baptist Home Mission Societies. Some years ago eight of the 22 beds were converted into long term care units for eight nursing home patients. This provides a steady income for the hospital but is not enough to keep things in the black.

Much local support and energy goes into the hospital. The five full time nurses, laboratory assistant, and part-time laboratory technician are supplemented by high school girls who have been trained as nurses aides. In 1969, with the help of a local nurse (who has done an excellent job of training these girls) the course was expanded to include more material. And now, in 1970, we have developed a vocational education course in the local high school for the training of nurses aides, with the hope that these girls may have some background for becoming licensed vocational nurses or perhaps even registered nurses. From the first group of nurses aides in 1968, we have one girl who is now in Seattle in nurses training.

Maternity care is the large part of the hospital's operation. We have a fully equipped delivery room and can also handle emergency surgery, normally no more than an appendectomy or hernia, other surgical patients being sent to Anchorage. Within recent months we have had a growing number of patients with heart conditions but due to lack of funds we do not have the heart monitoring equipment that is necessary. We are, however, able to send our EKG's to Anchorage via telephone lines. This recent development has been of aid to our physician. The laboratory recently obtained new equipment through the collection of Betty Crocker coupons. Two of the largest items which were obtained were a new EKG machine and a flame spectrophotometer.

The advent of Medicare has brought many problems because of the requirements of the program. For instance, the requirement of a trained dietician, a medical record librarian or a Utilization Review Committee are difficult to meet for a small hospital such as ours. The Utilization Review Committee has been particularly difficult because there is only one doctor in the community and he is on 24-hour call. With the Medicare program, costs have had to be increased in order to meet the requirements for additional staff that

they feel necessary to provide medical care. Even if we were to obtain consultant dieticians or medical record librarian there is still the expense of travel, per diem and consultant fees; which add greatly to the medical cost of the patient.

In our particular situation, with a community economy being somewhat depressed, the hospital occupancy had decreased (7 to 10%) last year. This increased our current financial plight and puts us well into the "red". A medical care institution cannot shut down when occupancy is low, we must keep operating and maintain a staff and pay salaries even with our patient load down. It is necessary to remain prepared for emergency and times when the hospital is busy.

Despite our decrease in patient load, we are talking about expansion and modernization of our facilities. It has been 15 years since the building was built and much of the equipment is older still. To keep up with the many advances in the field of medicine, we are hoping to make improvements which will enable us to provide better medical care for the residents of Cordova.

PALMER

by Mary L. Roberts

Located in Palmer, the heart of the Matanuska Valley, the Valley Hospital has served the Matanuska area since 1935. First built of log, the hospital was rebuilt in 1954 with the assistance of the Board of Missions of the Presbyterian Church, Hill-Burton and local funds. The new 25 bed facility includes two offices for the Public Health Nurse, six obstetrical beds with the large nursery, delivery room, operating room and a recovery room. Forty people are employed in the professional and service areas of the hospital. The medical staff includes three active physicians with the consultant and courtesy staff numbering 51 members. The hospital is aided by an active hospital auxiliary which is now raising funds to build a two bed coronary care unit.

VALDEZ

Valdez is the site of the state's second major mental health hospital, the 165 bed Valdez Memorial Hospital for the mentally retarded. The community of Valdez is allowed to use 15 of the hospital beds as general medical beds.

SEWARD

— A Little Community With Two Hospitals

SEWARD GENERAL HOSPITAL

by Thomas C. Alderman, CRNA

Seward General is a 34 bed, four bassinette, acute and short term care hospital. Built by the

City of Seward in 1957, it is operated by a board of local citizens. Two private physicians in Seward utilize the hospital, as do visiting physicians from the Soldotna-Kenai area.

The hospital is proud of its late model cardiac monitor equipment and its intensive care room. Recently four registered nurses completed the six week C.C.U. course sponsored by the RMP in Anchorage. One of the four recently took an advanced course in Seattle.

A steadily shortening length of stay has reduced the average occupancy to below 40%. Previously self-supporting, the hospital is now at the barely break even point and faces the future with problems of obtaining funds to keep the plant and equipment up to date.

WESLEYAN HOSPITAL FOR CHRONIC DISEASES

By Mildred L. Pelch, R.N.

Wesleyan Hospital fills a desperately needed spot in the Alaska hospital system. It is the only hospital in Alaska that cares for or has expressed a desire to care for patients with chronic incurable mental disease. As such, Wesleyan Hospital has patients from all over Alaska, many of whom were originally committed to the Morningside Hospital in Portland, Oregon and were transferred back to Alaska in 1967. Some of these patients have been institutionalized for 30 to 35 years. In addition, long term patients are transferred to Wesleyan from the Alaska Psychiatric Institute.

Originally constructed in 1952 as a nurses residence for the old Seward TB Sanitarium, it was converted to a hospital in July of 1958. It now functions as a 22 bed hospital but occasionally has had as many as 42 patients. Wesleyan is growing, with plans being implemented to add additional rooms along with a large day care room, dining room and a conference room for a staff. The additions will bring the original building up to Hill-Burton hospital construction standards. Wesleyan Hospital's medical staff includes a part time medical director plus two local physicians, five consultants and an active volunteer auxiliary group who participate with patient care activities.

SOLDOTNA-KENAI

The long awaited, urgently needed Peninsula General Hospital at Soldotna is in the final stages of construction (30 beds). With this new facility in operation the Kenai-Soldotna area should be able to attract specialists such as a general surgeon and an internist.

HOMER

With nine beds the Homer Hospital struggles, as do many of the other small hospitals, to provide adequate medical care with restricted budget, low occupancy and marginal facilities.

ANCHORAGE

Jealous of Seattle, Anchorage struggles and is succeeding in becoming Alaska's medical center. In addition to the large Elmendorf Air Force Base Hospital, the Alaska Native Health Service Hospital, and the State's Alaska Psychiatric Institute, Anchorage has two modern top flight private hospitals. Providence, with 150 beds is Alaska's "medical center". Its planned expansion of 100 beds will add desperately needed beds to the state. Community Hospital is number two and trying harder. Boasting a modern coronary care unit, it will soon implement a renal dialysis unit. Anchorage's two private hospitals provide each other constant competition, which occasionally teeters on the edge of destructive dissension.

THE ALASKA PSYCHIATRIC INSTITUTE

By Mildred Ostrom Mantle

The Alaska Psychiatric Institute has a unique role among the hospitals in Alaska, since it is the only one which has as its sole purpose the care and treatment of the mentally ill and retarded. It is a state hospital which opened in October of 1962, thus making it possible for Alaskans with mental illness to be hospitalized and treated in their home state. At the present time, it shares responsibility for Alaska's mentally retarded with Harborview Memorial Hospital in Valdez, Alaska, and has two wards devoted to this segment of mental illness.

Being less than 10 years old, it is modern in structure as well as in treatment concept. It is a 225-bed hospital functioning under an "open door" policy, a treatment plan which strives to maintain community contacts for patients, to which it is hoped they can be returned at the earliest possible time.

Located five miles southeast of the city center of Anchorage, it is situated in the area of greatest population within the state, although it serves all of Alaska. Its completion in 1962 ended 58 years of treatment of Alaska's mentally ill outside of their home state.

The present operation and program are funded through the state legislature, with special programs within the hospital receiving assistance from federal sources. These grants help provide staff for our Children's Unit and rehabilitative efforts through the joint projects of the Institute.

Admissions are either voluntary or through judicial commitment, with about 85 per cent of the present admissions being voluntary. Patients are referred to the hospital through mental health clinics in Anchorage, Fairbanks and Juneau and Mental Health Centers in Ketchikan and Kodiak. There are some who are admitted through private physicians, public health and educational personnel throughout Alaska, and some are admitted on an emergency basis. The open hospital concept permits patients to assume as much responsibility for themselves as is consistent with their ability. It also helps minimize the possibility of chronicity and dependency upon the hospital.

While the hospital has made great progress during the eight years of operation, it still faces many problems which must be met and solved before the mental health program of the state can be truly effective.

NORTHERN AND CENTRAL ALASKA

FAIRBANKS

Jealous of Anchorage, oriented towards Seattle, Fairbanks is just completing its new community hospital (110 bed) which will replace the obsolete 67 bed St. Joseph's Hospital. Severely damaged in the flood, the St. Joseph's Hospital was turned over to the Fairbanks community in 1968 by The Catholic Sisters.

NOME

Chronically plagued by its inability to attract a permanent physician, in addition to possessing an obsolete inadequate facility, Nome struggles with its 24 bed Maynard-McDougal Hospital. Nome now has one private physician and one Public Health Service physician and seems a logical place for the Public Health Service to expand its operation.

GLENNALLEN

FAITH HOSPITAL

GLENNALLEN

By James S. Pinneo M.D.

The village midwife looked up in despair — moss packing had failed to stop the bleeding; now the new mother was unconscious. Quickly the missionary was called, but with no medical training and scant equipment there was nothing he could do. That was way back in the 1930s, yet it dramatically underlined the vast medical needs of an area in Alaska about the size of the State of Pennsylvania without a single doctor.

In 1950 the picture was improved when the first missionary doctor arrived in Glennallen to

initiate the medical ministry of the Central Alaskan Missions. Good medicine was practiced under primitive conditions. At first people were reluctant to come to the little two-room shack which served as doctor's office, and home deliveries and house calls were frequent. After the second doctor arrived in 1954 the scope of practice enlarged to include village clinics, some as far as 250 miles from home base.

Better facilities were a must, but several attempts to secure Hill-Burton and State funds to help construct a hospital failed. Then in 1956 the first section of Faith Hospital was completed, financed entirely by private funds. A limited number of patients could be admitted for medical, surgical and obstetrical care. However, it soon became evident that the original building could not handle the patient load.

Attempts in 1963 to enlarge to provide better out-patient areas ended in another frustrated financial bind. Instead of constructing needed space it was necessary to spend \$75,000.00 on a sewerage treatment plant and lagoon. At last, in 1969 the new out-patient wing was added.

Present facilities include eight in-patient units plus a nursery, a fully equipped operating-delivery room, two examining rooms, two offices, an emergency room, a modern x-ray unit, central supply and a laboratory-pharmacy, the only drug dispensing service within 145 miles. As space increased, the staff was decreased by the resignation of one doctor. This necessitated elimination of village clinics, but by now most of the general public have been convinced that hospital-based medical care is more ideal than house calls which leave the patient inadequately diagnosed and treated, and the physician overextended physically and emotionally.

As population in the area increases due to the success of "Seward's Folly", it is obvious that medical facilities must also enlarge. The next proposed expansion is a dental clinic to provide good preventive dentistry aimed at decreasing the almost daily "emergency" tooth extractions now being performed.

But good medical care is more than modern buildings and equipment — it is also people — well trained, qualified professionals with a full complement of para-medical help. How could a small, privately-owned hospital way out in the "boondocks" of Alaska ever hope to attract and hold such personnel? Faith Hospital is owned and operated by Central Alaskan Missions, Inc. All of its professional staff, consisting of one doctor, four full-time R.N.s and several part-time nurses, are non-salaried missionaries whose living expenses are supplied by donations from interested churches and individuals in the "South 48".

Para-medical help has been more difficult to secure. Consequently nurses have had to operate the pharmacy while the doctor has done most of the laboratory and x-ray work, to say nothing of dental and veterinarian "emergencies". Occasional visits by ophthalmologists and dentists have been a tremendous boon. Perhaps a better developed program of visiting professionals and para-medics would be the answer.

Beside personnel shortage which is common to all medical installations, the "bush" hospital faces a rather unique difficulty. Bureaucracies of insurance companies, Blue Cross, Medicare and other third-party payers seem to have no provision for a doctor who operates a hospital out-patient service single-handed. "Are these charges for an office visit or out-patient clinic?" "Please submit a complete re-billing clearly differentiated."

Another problem inherent in this type of practice is the 24-hour service expected of a hospital. One doctor on call 24 hours a day, seven days a week soon finds himself overextended, to say the least. Temporary relief has been realized through visits of doctors from Anchorage and "outside" for periods ranging from a few days to several weeks. However, another full-time missionary doctor is a must if adequate medical care is to be maintained in the Copper River Basin.

Medical missionary work is more than extending medical care to people in a remote area. It is an integral part of the overall purpose of the Mission to meet spiritual as well as physical needs. Dedication of the professional staff of Faith Hospital is to something more than amelioration of physical and emotional perplexities of this life; it is dedication to the service of Jesus Christ — "*Whom to know aright is Life Eternal*".

BRISTOL BAY-KODIAK AREA KODIAK

Kodiak boasts a new 25 bed general hospital which like so many hospitals in Southeast is hampered by the drain of ANS patients to Anchorage, under-utilizing the hospital and increasing patient care costs.

DILLINGHAM

Dillingham's private physician does his tonsillectomies and deliveries in his basement clinic. By federal regulation he is prohibited from practicing medicine in the nearby Kanakanak Hospital with its modern facilities.



MEDICARE AND THE HOSPITALS IN ALASKA

By Anna M. Wenzel

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Alaska is widely known as the largest of the United States; however, less well known, is that it is the smallest in terms of the Medicare Program. There are less than 7,000 persons in Alaska who are eligible for Medicare benefits. At present, 21 hospitals strung from Barrow to Ketchikan are fully certified as providers of services to these Medicare beneficiaries. (See Fig. 1.)

A brief review of the basis for activities is essential to discussion of how the Medicare Program is working in Alaska. Public Law 89-97, enacted as an amendment in 1965 to the Social Security Act, establishes through Title XVIII (the Health Insurance title) certain requirements which hospitals must meet in order to participate in the Medicare Program. Provision is made for the Secretary of Health, Education and Welfare to expand these requirements through Federal regulations; such regulations represent standards developed in consultation with organizations and experts in various medical and paramedical fields. The complete lists of requirements are published as the Conditions of Participation. For hospitals, these are as follows:

- I. Compliance with State and Local Laws
- II. Governing Body
- III. Physical Environment
- IV. Medical Staff
- V. Nursing Department
- VI. Dietary Department
- VII. Medical Record Department
- VIII. Pharmacy or Drug Room
- IX. Laboratories
- X. Radiology Department
- XI. Medical Library
- XII. Complementary Departments
- XIII. Outpatient Department
- XIV. Emergency Services or Department
- XV. Social Work Department
- XVI. Utilization Review
- Special Medical Record Requirements
for Psychiatric Hospitals
- Special Staff Requirements
for Psychiatric Hospitals

LOCATION OF CERTIFIED HOSPITALS
August 1969 — November 1970



FIGURE 1

The conduct of the program has been delegated by the Secretary, HEW, to the Commissioner of Social Security. Congress has provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields. In Alaska, the Department of Health and Welfare, through its Medical Care Unit, performs the required activities in certification of providers; all claims for services provided to Medicare beneficiaries are handled by either Blue Cross of Washington and Alaska (Seattle), or Aetna Life Insurance Company (Portland, Oregon).

Hospitals must meet certain statutory requirements and there must be a finding by the State Agency of substantial compliance with all the other conditions. The specific statutory requirements under Title XVIII are that the hospital:

1. is primarily engaged in providing to *in-patients* by or under the supervision of physicians,
 - (a) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or
 - (b) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
2. maintains clinical records on all patients;

3. has bylaws *in effect* with respect to its staff of physicians.
4. has a requirement that every patient must be under the care of a currently licensed physician;
5. provides 24-hour nursing services rendered or supervised by a currently registered professional nurse, and has a currently licensed practical nurse or registered professional nurse on duty at all times;
6. has *in effect* a hospital utilization review plan which meets specific requirements;
7. is licensed pursuant to applicable State and local laws;
8. meets other requirements prescribed by the Secretary, HEW.

These “other requirements” are related to the quality of care and the adequacy of the services and facilities which the hospital provides. They represent essential functions to be performed by the hospital and its staff in order to satisfy the requirements for participation. The manner in which these functions are performed differs from each hospital as there are variations in the type and size and also in the nature and scope of the services offered; thus there are differences in the details of organization, staffing, and facilities. For example, of the 21 fully certified hospitals in Alaska, only two (2) have a bed capacity of over 100. The number of certified beds ranges from 3 to 225. Excluding the State’s psychiatric hospital (225 beds), the average number of certified hospital beds is 37, with a median of 26 beds. There are 969 certified hospital beds in Alaska.

One other statutory requirement that must be met relates to non-discrimination, under Title VI of the Civil Rights Act of 1965, because of race, color, or national origin.

Findings made by the Medical Care Unit as to whether or not a hospital is in substantial compliance with the Conditions of Participation requires a thorough evaluation which takes into consideration:

- (a) the degree to which each standard, as well as the total set of standards relating to a Condition of Participation, are met; and
- (b) when there *is* a deficiency in meeting a standard whether the deficiency
 1. concerns a statutory requirement, or
 2. creates a serious hazard to health and safety,

3. whether the hospital is making reasonable plans and efforts to correct the deficiency within a reasonable period.

Now, what were some of these findings?

Surveys conducted between August, 1969 and November, 1970, were reviewed. It was found in some situations that certain conditions and/or standards were not applicable; for instance:

- 11 hospitals did not have an Out-Patient Department
- 15 hospitals did not have a Social Work Department
- 5 hospitals (Federal) did not need State licensure
- 15 hospitals did not divide their medical staffs into departments nor did they have chiefs of services or departments
- 7 hospitals did not have departments of dentistry nor dental staff
- 15 hospitals did not have rehabilitation, physical therapy, and occupational therapy departments.

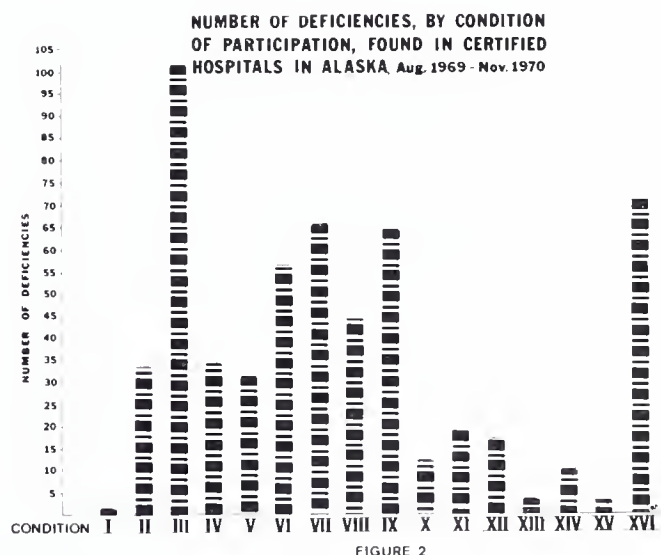


Figure 2 shows by numbers and by Condition where the deficiencies — major and minor are lumped together — occurred as of the date of the survey. This does not, therefore, reflect the corrections made subsequent to the surveys. It will be noted that deficiencies are most frequently found in relation to Condition 405.1022 — *Physical Environment*. Of the 21 fully certified hospitals, more than half of them were *initially* constructed over 15 years ago (range from 1906 thru 1955). To be sure, there were renovations and additions to about half of these, but the fact remains that these are primarily still old structures. It is understandable, therefore, why structural deficiencies accounted for almost one-fourth of the cited deficiencies. More than one-half of the deficiencies related to fire control, and little more

than one-fourth with the sanitary environment (this standard deals primarily with infection control and most of the deficiencies related to the lack of current, written, and routinely reviewed infection control measures which were operative).

The next most frequently cited deficiencies occurred in Condition 405.1035 — Utilization Review. A few words about the role of the State Agency in evaluating this UR requirement is appropriate here. It is necessary to make a review of the hospital's formal UR plan for statutory sufficiency, and appraisal of whether the UR committee is in fact conducting its function. *At no time does the State Agency review or evaluate the correctness of UR committee decisions made in individual cases.* Although all hospitals had written UR plans, many of them needed revisions necessitated by changes that had been made in the *composition of the UR committee, the method in use for selecting cases for review, and the definition of the number of days constituting extended duration.* Four (4) hospitals did not meet the total standard relating to "Review" (statutory requirement). When all the factors for this particular standard were considered, seventeen (17) hospitals did not meet all the factors related to the "Records" standard. Without doubt, this condition is the most troublesome, particularly for the isolated small hospitals with only one or two physicians.

Following in descending rank order were deficiencies relating to medical records, laboratories, dietary, pharmacy, medical staff, governing body, nursing, medical library,

complementary departments, radiology, and emergency service. The single deficiency related to lack of current licensure by personnel required to have State licensure.

Definition of "problem" areas serves little constructive purpose unless there's some attempt to *do* something about them. All of the deficiencies are correctable — some immediately, others take varying periods of time, and yet others may be extremely difficult to correct within the present financial capabilities of the providers. To correct some of the structural deficiencies, some of the hospitals must receive financial assistance from other than their own sources of revenue. That the hospitals are doing something about their cited deficiencies is evidenced by, e.g. new construction to replace 2 of the oldest hospitals and JCAH accreditation of two hospitals not previously accredited. On the basis of continuing analysis of where the major deficiencies occur, the Medical Care Unit provides consultative assistance — e.g., a physician consultant for utilization review activities; dietary consultants; and some medical record consultation. With input from the hospitals, this Unit is planning assistance with staff development through various related workshops (e.g., infection control; social services).

In providing this sketch of the Medicare Program in Alaska, I have discussed only the certification aspects which are my responsibility and have not attempted to include the impact on this Program by the rising health care costs. These are not discounted, however, as the effect on the other "problems" mentioned is recognized.



ALASKA AREA NATIVE HEALTH SERVICE

By John Lee, M.D.

Area Medical Director, USPHS, Anchorage

Prior to the mid-1860's health care services as we know them today were nonexistent in many Alaskan villages. Those native people who lived in a locality served by medical missionaries were provided with limited medical services. For the few villages located along the West and Northwest coastal areas, the medical officers on board the Coast Guard vessel which made yearly visits afforded their only contact with modern medicine. Today the 54,000 Alaska Native peoples (who include Aleuts, Eskimos and Indians) receive their medical care from a modern, up-to-date hospital system which delivers medical care from Barrow to Ketchikan and reaches into virtually every native village and home in Alaska. The Alaska Area Native Health Service operates as part of the Indian Health Service, a division of the Health Services and Mental Health Administration of the United States Department of Health, Education and Welfare.

To provide competent, effective and locally responsive care to the Alaska Natives, Alaska Native Health Service programs are administered through seven service units which cover the entire State of Alaska. Each service unit is headed by a Service Unit Director (SUD) who is responsible to the Director of Alaska Native Health Service in Anchorage. Each Service Unit Director and his staff are supported by a full range of health care programs with technical, and administrative specialists located in the Anchorage area office to provide back-up. Clinical speciality consultation to the far-flung service unit hospitals and facilities is available through the Alaska Native Medical Center in Anchorage.

Central to the Native Health Service system in Alaska is the Alaska Native Medical Center. Built in 1953 as a tuberculosis hospital, it added 400 beds to the all-out attack which was then being waged on tuberculosis. As the years progressed, its role has gradually changed until now it is a general medical and surgical hospital serving the more than 10,000 Alaska Natives living in the Anchorage Service Unit, and providing clinical back-up and speciality consultation to the other service unit hospitals throughout the state. To aid in the difficult and sensitive task of providing health services, the Alaska Native Health Center (like all service unit hospitals) has a Native Board of Health, which participates actively in the planning and development of all programs.

The Alaska Native Medical Center provides a myriad of services. It works closely with many organizations, agencies and individuals in the

development and implementation of health programs. Close ties with the Anchorage Borough Health Department aid in providing care for the almost 4,000 Alaska Natives resident in Anchorage. With the Alaska Department of Health and Welfare, the Alaska Native Medical Center participates in many programs.

Training and education play a major role in the hospital and the Center — not only as the focal point for the training of village health aides. The Alaska Native Medical Center participates with the University of Alaska in the licensed nursing program and with Alaska Methodist University in the baccalaureate degree program for nursing. It also has its own intramural dental internship program and participates with "outside" institutions in the training of residents in general surgery, ophthalmology, otolaryngology and pediatrics. These residency programs, respectively, put the Alaska Native Medical Center in close contact with such far-flung hospitals as the Public Health Service hospital in Staten Island, the Public Health Service hospital in Baltimore, the University of Chicago, and the University of Oregon.

The Alaska Native Medical Center has participated and collaborated with the Arctic Health Research Center in basic studies in epidemiology, tuberculosis, infectious disease and cardiovascular disease. Other studies have included bronchiectasis, INH metabolism, diabetes, heart and genetic metabolic defects, otitis media, respiratory and viral infections, infant morbidity and mortality, and frostbite.

Beside being the supplier of primary medical care to the natives resident in the Anchorage Service Unit, the Alaska Native Medical Center has as its second major function the provision of a constant and high quality backup for the smaller service unit hospitals. This backup is provided by a training program system, telephone and teletype consultations with the specialists, and the provision of traveling speciality clinics to the different service unit hospitals. Further, the Alaska Native Medical Center is the referral hospital for all of the complex and difficult cases which cannot be handled at the service unit level. Because of the close ties and constant communication which exists between the Alaska Native Medical Center in Anchorage and the service unit hospitals, the smaller distant hospitals function as an extension of the large parent hospital in Anchorage. This provides a smooth and integrated system of health care and patient flow. In areas where service unit facilities are not available, care of the Alaska

Natives is provided on a contract basis with the Alaska Native Medical Center still acting as the base of referral for the complex and difficult patients or for long-term hospitalization.

Like all other service unit hospitals, the Alaska Native Medical Center has an extensive field health program with regularly scheduled physician and Public Health nurse visits to the many small villages and communities in the Anchorage Service Unit — which extends from the Pribilofs and the tip of the Aleutian Peninsula to the Canadian border. The backbone of the field health program is the village or community health aide. Selected by the village government, these aides are trained both at the local service unit hospital and at the Alaska Native Medical Center. With only basic equipment and remote supervision, these aides are the only source of health and medical expertise in many communities.

The functioning of the Alaska Native Medical Center is hampered by an obsolete physical plant which is crowded and inappropriately designed. Remodeling of some departments has been accomplished and more is planned. However, repeated remodeling of an obsolete structure is only a stop-gap. We are planning more suitable building and location. Usage of basic supportive facilities in common with one or more hospitals in the community will undoubtedly be encouraged through comprehensive health planning. It is the policy of the Indian Health Service to cooperate with this planning as has been done in several other communities in Alaska.

The future holds expansions of services for hearing loss, otitis media, eye programs, chronic respiratory diseases, socioeconomics and alcoholism. With the increasing age of the Native population there will be an increasing need for medical management of many of the degenerative diseases.

Each of the six remaining service units has its own set of problems and uniqueness. The basic mission remains the same and much of the operational procedures are identical. Yet each of the hospitals is as different as the widely-separated areas of the state in which they function.

THE BARROW SERVICE UNIT

Covering the entire North Slope, from the Brooks Range northward is the Barrow Service Unit with its modern, fourteen-bed general, medical and surgical hospital located in Barrow. The hospital was built in 1964 and is staffed with two physicians, a dentist and a social worker in addition to the usual medical support facilities. A busy outpatient clinic averages 950 patients per month with an average of six patients hospitalized at any one time.

A field program provides services to the villages of Wainwright and Kaktovik. As in most of the other service units, pediatric problems constitute a major segment of the medical practice. Impetigo, otitis media, diarrhea, pneumonia and the sequela of these infections account for approximately 40% of the clinic visits:

BETHEL SERVICE UNIT

Covering the outlet of Alaska's two great rivers, the Yukon and the Kuskowim, the Bethel Service Unit spans approximately 85,000 square miles of Southwestern Alaska. The 42-bed general, medical and surgical hospital provides medical services to the 15,000 people living on the great Yukon-Kuskokwim Delta. The hospital is supplemented by a health center staffed with one physician at Aniak and several health stations in villages throughout the Yukon-Kuskokwim Delta. With seven physicians seeing an average of 80 patients daily in the outpatient clinic; a busy inpatient service which at times has gone as high as sixty or seventy patients, and providing extensive field services along with the daily radio-medical traffic, the Bethel hospital is one of Alaska's busiest. In fact, the hospital boasts the Alaska Native Health Services largest obstetrical practice — delivering some 400 babies yearly; many of the deliveries being complicated by the problems of high multiparity and marginal diet. Spaced throughout the year are many visiting speciality clinics which put an increased burden on the hospital, particularly those with general surgery, eyes, ears, and throat, which utilize the operating room facilities.

To cope with the high incidence of mental health problems in the Bethel community and the surrounding area, a full-time social worker supplements the activities of the physicians which are closely coordinated with the State, the Bureau of Indian Affairs, and local efforts.

The Bethel Hospital serves as the training hospital for the advanced health aide program under the auspices of the Yukon-Kuskokwim Health Corporation.

KANAKANAK SERVICE UNIT

Sixteen miles from Dillingham, at the head of Bristol Bay, is the Kanakanak Hospital. This 38-bed medical and surgical facility provides care for the 3,800 Alaska Natives living in the Bristol Bay area. Supplementing the two physicians in the Kanakanak Hospital is a private physician practicing in Dillingham, and two Alaska State Department of Public Health nurses, also located in Dillingham. A third Public Health nurse is located in the Naknek area.

Like all Alaska Native Health Service Hospitals, trauma accounts for a large portion of the problems encountered. Injury and death from house fires, boating accidents, traffic accidents, falls and other accidents are a major health problem. Extended hospitalization for treatment of infected wounds and burns account for a significant proportion of inpatient days. Abuse of alcohol contributes to many of these accidents. The pattern of injuries varies seasonally and is particularly influenced by the large influx of fishermen and cannery workers during the salmon season when the population of Bristol Bay Region has been estimated to double.

KOTZEBUE SERVICE UNIT

Straddling the Arctic Circle and facing westward into the Bering Sea, the Kotzebue Service Unit covers approximately 80,000 square miles and includes the community of Nome. Per capita income of the Kotzebue Service Unit is the lowest of all of the areas of the state and was \$1,028.23 in the year of 1967. Like the Bethel and Kanakanak Service Unit, the majority of the residents of the Kotzebue area eke out a subsistence living by hunting and fishing. Health is poor with the problems of otitis media, impetigo, diarrhea, respiratory diseases and mental health being prominent.

A modern 54-bed general, medical and surgical hospital located in Kotzebue is supplemented by the twenty-eight bed Maynard-McDougal Hospital in Nome. Staffing the Kotzebue Hospital are four physicians and one dentist. An additional Public Health Service physician is assigned to Nome to assist the one private physician in that area. Five Alaska State Department of Public Health nurses are located in the Kotzebue area and travel quarterly to their respectively assigned villages. The Alaska State Tuberculosis Control team also visits the villages of the service unit. The Public Health Service physicians from the Kotzebue Hospital make bi-annual visits to each village (staying two to four days, depending on the size of the village) and provide such services as prenatal examinations, pre-school and school-age children examinations, routine pelvic and pap smears on adult women, fitting of glasses and training the health aides in their function. Like the other service units, specialty clinics are held throughout the year.

Daily radio contact with village health aides is a vital part of the health program of any bush hospital. Like the Bethel, Kanakanak, or Barrow Service Units, daily radio contact is made with a Community Health Aide in each of the villages in the Service Unit concerning health problems of patient in the village. The radio communications are monitored twenty-four hours a day to intercept emergency traffic.

MT. EDGECUMBE SERVICE UNIT

The Mt. Edgecumbe Service Unit covers the entire Southeastern area of the State of Alaska and is responsible for the health care of approximately 14,000 Native people. The service unit is headquartered at Mt. Edgecumbe adjacent to the city of Sitka. The Mt. Edgecumbe Hospital is a 130-bed medical and surgical facility. During the year 1969 there were 1,441 admissions to the Mt. Edgecumbe with an average daily patient load of 67.6. In addition, the Mt. Edgecumbe Hospital provides care to veterans under contract with the Veteran's Administration, to commercial fishermen by reciprocal agreement with the Public Health Service Hospital in Seattle and to foreign seamen in emergency situations. Specialty clinics, such as orthopedic, radiologic, neurologic, and ophthalmologic are provided through the cooperative efforts of the Alaska Area Native Health Service, the Alaska Department of Health and the Washington/Alaska Regional Medical program.

The medical staff is composed of an internist, a general surgeon, two pediatricians and four general medical officers. The hospital has an up-to-date five-chair dental clinic with an active dental assistant training program. The Mt. Edgecumbe Service Unit carries out extensive community health services programs with health, education and environmental health services as well as medical care being provided to the people in the outlying villages.

There are outpatient clinics located in Juneau and Ketchikan, each of which is staffed by two physicians and a dentist, along with support personnel. A physician is located on Annette Island for the care of the Metlakatla citizens, and the Coast Guardsmen of the Annette Island Coast Guard base. The contract health services program provides for health services in community hospitals by private physicians in the larger communities throughout Southeastern Alaska.

TANANA SERVICE UNIT

Covering the vast central area of Alaska with its headquarters located at Tanana is the Tanana Service Unit which includes Fairbanks — Alaska's second largest Native community. The Native population for this area is approximately 7,000 people. The twenty-six bed general hospital at Tanana is supplemented by medical facilities in the Fairbanks area. The new Fairbanks Community Hospital will include 19 beds for the use of Alaska Natives, in addition to an outpatient clinic in the Fairbanks area. Currently there are three physicians in the Tanana Hospital and one physician in the outpatient clinic in Fairbanks. Contract medical services are provided to supplement the service units direct care facilities.

Drug abuse has become an increasingly important problem in the Tanana Service Unit, especially in Fairbanks. There is reason to believe that pushers may be attempting to expand their enterprise out to the villages.

THE FUTURE

As old problems are resolved, relatively untouched or unsolved major health problems come to the foreground. In these categories are mental illness, alcoholism, chronic diseases of the aged, nutritional disorders and the overwhelming problem of dental care needs, and others. The problems are great, but not insurmountable.

Greater participation in the health delivery system by the Alaska Native people and increased

cooperation with other agencies such as the State Division of Health and Welfare, local communities and private organizations will be stressed by the Native Health Service in an effort to meet the total needs of the people.

The direction of the Alaska Area Native Health Service for the immediate future as seen today will be to:

1. Emphasize prevention by concentration of effort at the village level.
2. Continue to upgrade the quality of hospital care and broaden the range of other services.
3. Promote the blending of Alaska Area Native Health Service with the State, community and consumer resources and efforts.



THE DEVELOPMENT OF MODERN MEDICINE IN SOUTHWESTERN ALASKA

I. The Growth of Health Services

By Robert Fortune, M.D., M.P.H. *

* Formerly Service Unit Director at the PHS Alaska Native Hospitals at Kanakanak (1963-64) and at Bethel (1964-67). Present position — Service Unit Director, PHS Indian Hospital, Fort Defiance, Arizona 86504.

INTRODUCTION

Southwestern Alaska, the area between Norton Sound and the Alaska Peninsula, is perhaps less known to Alaskans than any other part of the State. It is a vast isolated area, difficult and expensive to reach and with none of the apparent glamor of many other regions. Tourists rarely venture there, even in these days of package tours and jet airplanes, while the big game hunters seek their trophies on the Arctic Coast or in the mountains of the interior. No oil wells have begun gushing forth black gold through the permafrost. Even the commercial salmon industry, the region's traditional source of wealth, has lost many of its followers and most of its profits compared with a couple of generations ago.

The great resource, little appreciated and almost criminally underdeveloped, is the people of this barren region. The Yuk Eskimos, together with some Athapascan Indians and a few persons of Aleut extraction, deserve better than the poverty, illiteracy and wretched health which has been the cruel lot of most for the past hundred years.

This paper, in two parts, is concerned with the health of the people of Southwestern Alaska. The present essay deals with the development of modern health services in the region, from the earliest missionary activity to the many agencies and organizations which now contribute, despite serious physical and financial obstacles, to the gradual betterment of health conditions. Part II, which is proposed for a future issue of *Alaska Medicine*, will trace in greater detail the impact of disease on the history of the region, summarize the extent and patterns of disease as they are reflected now, and review the significant contributions to medical science which have had their origin in the study of this population.

HISTORICAL BEGINNINGS

The tundra, coastal regions, rivers and forests of southwestern Alaska have always been isolated,

because of the formidable barriers of mountains, wilderness, and treacherous coastal waters which encompass them. Captain Cook, on his northern expedition in 1778, entered and named Bristol Bay. Rounding Cape Newenham, he almost immediately found himself surrounded by shoal water in the estuary of the Kuskokwim River and without delay stood out for sea. Such was the experience of most of those who approached by sea, whether Russian explorers, whalers, Revenue Cutters, or in our own day Coast Guard vessels or supply ships.

The land approach was similarly difficult. Explorers and traders were discouraged by great expanses of wilderness, mountain ranges and the severe climate. Russians were trading in the Nushagak Bay region as early as 1786, however, and from a base there had expanded their operations into the Kuskokwim Valley by the early 1830's⁴. Meanwhile Russian explorers had been surveying the coasts of Bristol Bay and to a limited extent the region between the Kuskokwim and the mouth of the Yukon. Other overland expeditions from St. Michael were gradually penetrating the lower reaches of these great rivers, where a surprisingly large local population was encountered.

The only written records from this period are the diaries and reports of these traders, missionaries and explorers who led a harsh and lonely life far from their homes. An occasional reference to the health of the Natives appears in these writings. Undoubtedly these men offered medical assistance to the local people to the extent their skills allowed, but they were generally helpless in the face of serious disease.

The Natives themselves, of course, had a highly developed system of their own for dealing with sickness and injury. Not only did their shamans deal with the more intangible causes of illness such as soul-loss and sorcery, but many other persons apparently had knowledge of the healing effects of plants, animal products, and minor surgical problems.¹¹

Both Russians and Natives, however, were powerless to cope with the devastating effects of introduced diseases to which the latter had no immunity. Smallpox swept through the region with fearful mortality in 1838 and 1839, having been introduced from Unalaska through Bristol Bay. Under the direction of a German physician, Dr. Blaschke, Surgeon's Apprentice Formin was sent to Bristol Bay to vaccinate the local population. Formin was perhaps the first individual to bring the techniques of "modern" European medicine to this region. He was not notably successful in his endeavor, for many resisted his efforts¹³.

THE MORAVIANS

After the transfer of Alaska to the United States in 1867, the southwestern area was relatively neglected, except for a few fur traders, explorers and scientists, until 1884. In that year, at the urging of Rev. Sheldon Jackson, a group of Moravian missionaries arrived on the Kuskokwim, where they established a base of operations in the tiny settlement they renamed Bethel.

From the very beginning of their endeavor they recognized the stark need for medical skills to supplement their spiritual activities. Not for 12 years, however, was the church able to recruit a qualified physician for service in Alaska. J. Herman Romig, brother-in-law of one of the first missionaries in Bethel, prepared himself for many years for just such a task. When he sailed for Alaska in the summer of 1896 he had graduated from the Hahnemann Medical College in Philadelphia and completed some post-graduate training in surgery. He undertook his work with the avowed goal of changing the belief of the people in the cause and cure of sickness¹⁶.

Dr. Romig became a potent force in the affairs of the mission during the seven years he remained at Bethel. His "hospital" was a crude two-room log cabin, one room serving as a dispensary and operating room and the other as a two bed ward. At first his practice was largely confined to the missionaries and their families, until he was able to gain the confidence of the Eskimos. The latter for the most part were quite happy with the services of their shamans, at least until they became acquainted with some of Dr. Romig's surgical feats. Many were filled with awe when in 1899 he amputated the arm of his brother-in-law for a spreading infection¹⁷.

Romig traveled widely by dog-team, making journeys of hundreds of miles to the Yukon, the Upper Kuskokwim, and across the mountains to Bristol Bay. On these journeys he found himself operating in sod igloos, kashiges, sweatbaths, trading posts and missions³.

In 1900 a terrible epidemic of influenza struck the lower Kuskokwim, Yukon and Nushagak Bay regions, while Romig was engaged in a survey for the 12th Decennial Census. Hundreds died throughout the area, with the living hardly sufficient in numbers to bury the dead. Though the doctor worked courageously during the epidemic, he was of course powerless to alter its deadly progress. As a result, many of the Eskimos, encouraged by their shamans, lost confidence in Dr. Romig's medical skills. Rebuilding their trust was a long and arduous task^{14, 17}.

In 1903 Dr. Romig left Bethel on furlough but returned the following year, this time to the Moravian settlement at Carmel, on Nushagak Bay. There he divided his time between the mission work for the Eskimos and part-time employment in the local salmon canneries, several of which had been built nearby. It was his hope and that of the mission that his dual endeavor would be financially self-sufficient, but after a year Dr. Romig reimbursed the mission for their investment and retired to private practice in San Francisco.¹⁷ The great earthquake of 1906 destroyed his plans, however, and in 1908 he was back at Carmel, this time opening a small hospital and clinic in some abandoned mission buildings.²⁰ Over the next few years he did contract medical work for the Bureau of Education as well as serving as District Superintendent of Schools. His subsequent distinguished career with the Bureau of Education and the Alaska Railroad is beyond the scope of this paper.¹⁶

After Romig's departure from the Bethel area, no other doctors were forthcoming for a number of years, despite the steady growth of the mission and the community. The annual reports of the mission staff during this period amply documented the continued need for medical skills. It was not until the Federal Government recognized its responsibility to the Natives, however, that another physician took up the work of this pioneer of southwestern Alaska.

THE BUREAU OF EDUCATION

Due again to the efforts of Rev. Sheldon Jackson, a domestic reindeer herd was introduced at Bethel in 1901 in an effort to bolster the local economy. As the government herd grew, Akiak, a small settlement a few miles upriver from Bethel, became the center of operations. It was there in 1916 that the Bureau of Education built the first government hospital in southwestern Alaska, a tiny two-story frame building staffed by a doctor and a single nurse. This hospital, with about 16 beds, remained the only medical facility on the Kuskokwim until 1937, when erosion from the river caused it to be dismantled¹⁷.

In 1918-1919, shortly after the hospital opened its doors, the so-called "Spanish influenza" swept over the Bristol Bay and Lower Yukon regions like a tundra fire. Dr. Frank Lamb, the physician in charge of the Akiak facility, left immediately for the lower Yukon to do what he could to help the countless victims and to enforce a strict ban on travel to the unaffected villages, particularly along the Kuskokwim River and the Bering coast. At Hamilton, on the Yukon delta, Dr. Lamb himself succumbed to the disease, leaving his mother, wife and son at Akiak¹⁷.

Health conditions went from bad to worse during this period. Many children were orphaned or abandoned as a result of the epidemic. People of all ages, weakened by influenza or pneumonia, were easy prey to tuberculosis, which was assuming epidemic proportions in its own right among the Natives.

The Bureau of Education took what steps they could within the niggardly appropriations available to them from Washington. It provided each school with a medicine chest and if possible assigned at least one teacher who was either a nurse or who had had a training course in first aid⁸.

In 1918 they enlarged and remodelled as a hospital an old school building at Kanakanak, across the bay from Nushagak. The following year, after the great epidemic, the Bureau constructed an orphanage near the same site. The orphanage later became an industrial training school and still later the buildings were added to the Kanakanak hospital site as quarters. The original hospital itself was destroyed by fire in 1932²⁰.

The approach by sea was also tried. The *U.S.S. Boxer*, on which the Bureau operated a floating vocational school after 1920, usually carried a doctor and a few nurses during its summer cruises along the Bering Coast⁸. The U. S. Revenue Marine (later Coast Guard) steamers also carried a doctor, usually a Public Health Service Officer, but the episodic visits of these vessels were limited to the larger coastal settlements and could make little impact on the health status of the people.

About 1926 the Bureau tried the expedient of putting a medical vessel in service along the Yukon River to provide assistance to the villages and fish camps during the summer months. Dr. J. W. Houston, the medical officer on board that summer, saw 1400 patients in 74 communities before he fell overboard and was drowned in the river near Mt. Village*^{13, 15}.

About 1929 the Bureau built a small hospital at Mt. Village, which was a growing community near the site of several large canneries. The doctors

at this hospital traveled widely up and down the river during the winter months, providing the first regular access to medical care for many persons in this region. The hospital was short-lived, however, for less than ten years after it opened the building was so badly damaged by settling of the foundations that it had to be dismantled. Materials from the structure were later used in the construction of new hospitals at Bethel and Kotzebue.

THE BUREAU OF INDIAN AFFAIRS-ALASKA NATIVE SERVICE

In 1931 the Bureau of Education at last gave up its anomalous position of providing medical care to the Alaska Natives. Despite the fact that appropriations for medical services had increased over fivefold (to \$319,000) since 1918, the Bureau had made little positive gains in the health field, particularly in southwestern Alaska⁸. It was estimated at the time that less than 5 per cent of the Eskimos needing hospitalization could be accommodated by the existing facilities.

In March of that year the medical functions of the Bureau of Education were turned over by Executive Order to the Alaska Native Service (ANS), the Alaska regional office of the Bureau of Indian Affairs. Little change in policies, staffing, facilities, or health indicators were immediately noticeable, however, largely because annual health appropriations remained low. Although over the years the health funds gradually increased, the ANS was always plagued with problems of recruitment and retention of staff as well as a failure to recognize that real progress in health could only be achieved by more emphasis on prevention, housing and education, rather than on the treatment of the already ill⁸.

Under the ANS several facilities were either newly built or replaced. In 1937 the Service decided to replace the old Akiak hospital with a new 36 bed hospital at Bethel. As the importance of the reindeer industry declined, Akiak had lost importance in favor of Bethel, the headquarters of the Moravian mission and the head of deep water navigation on the Kuskokwim. The first Bethel Hospital opened its doors in January 1940, with Dr. Leslie White in charge¹⁷. For ten years this hospital gave fine service, for eight of them under the direction of Dr. Fred Langsam, perhaps the last physician in the region since Dr. Romig to speak the Eskimo language well.

Near tragedy struck on November 20, 1950 when on a cold wintery day a fire broke out in the furnace room and destroyed the entire hospital building. All 70 patients, including a number of cripples, were safely evacuated to private homes, the school and the mission¹⁷.

* The doctor's body was recovered and initially buried on the hillside above the village, but within a few years it was exhumed and returned to the "Lower 48".

For several years emergency outpatient services were provided in a large quonset hut near the old hospital site*, as a new building rose from the ashes of the old. This new hospital, the last to be built by the ANS, was a modern, single-floor 55 bed facility set on pilings thrust deep into the permafrost. When it opened its doors in 1954 a new era of medicine in this region was just beginning.

In Bristol Bay, meanwhile, the people were without a hospital from 1932 until 1940, when the present wooden structure, with an original capacity of 31 beds, was built and staffed by a single doctor and four nurses²⁰. In 1949 a large quonset hut wing was added for the hospital care of tuberculosis patients. Dr. John Libby, who was physician in charge during the later ANS years, has remained in Dillingham in private medical practice up to the present time.

THE ALASKA DEPARTMENT OF HEALTH (ADH)

The Alaska Board of Health was organized in 1945 and selected Dr. C. Earl Albrecht as the first Territorial Commissioner of Health¹. The Commissioner entered upon his duties with enthusiasms as the head of the newly reconstituted Alaska Department of Health. The first problem to be dealt with was tuberculosis, by now recognized by all as the major health threat in the Territory². Many new beds for the treatment of this disease were made available during these early years, and greater efforts in case-finding rapidly filled them.

One of the first tangible ADH activities in southwestern Alaska was the fitting out of several health vessels to provide both preventive and treatment services to the remote coastal and riverine villages. In the summer of 1949 the Department commissioned the *M/V Health*, which visited the Alaska Peninsula, Bristol Bay and Bering Coast communities, and the *M/S Yukon Health*, a self-powered river barge that operated along the lower Yukon as far as Holy Cross*. These vessels, which operated until 1952, provided chest x-rays, BCG vaccine, dental care, routine immunizations, well-child conferences and limited direct clinical services to the Natives of the region^{9, 15, 22}.

ADH also revitalized the public health nursing in southwestern Alaska about this time. Some nurses, under Federal auspices, had been available at Bethel since the early 1900's.¹⁷ By the time of

the Second World War the ANS was supporting nurses in remote areas, some of them itinerant and a few hospital-based.¹⁹ As the scope of the Health Department's activities grew, however, the Federal Government gradually turned over the public health nursing responsibilities to the Territory and later the State, where they remain today. The first ADH field nurse was assigned to Dillingham in October 1951, the same year in which three nurses were assigned to the lower Yukon-Kuskokwim area.²²

THE TRANSFER FROM ANS TO THE PUBLIC HEALTH SERVICE

By the early 1950's the Alaska Native Service had become increasingly uncertain of its ability to meet the health needs of the Alaska Natives adequately. Although two-thirds of the entire \$8 million budget were now going into the health program, the magnitude of the health problem seemed greater than ever, particularly in southwestern Alaska where tuberculosis was completely out of control⁸. Recruitment of scarce health professionals to work in isolated areas was also a perennial problem which seemed almost beyond solution.

Early in 1953 the Department of Interior, the parent agency of the ANS, saw the need for a comprehensive study of the health needs of the Alaska Natives, on the basis of which a new program of health services could be built. The task was undertaken through a contract with the Graduate School of Public Health of the University of Pittsburgh, the Dean of which was former U. S. Public Health Service Surgeon General Thomas Parran. The University team began its work immediately, visiting Bethel and the surrounding region during the summer of 1953 and again in 1954. Their report¹⁵, published in late 1954, was a detailed and hard-hitting survey of health conditions generally in Alaska, with particular emphasis on the unbelievably wretched conditions in southwestern Alaska*.

The Parran Report was not the first survey of its kind in Alaska, but it was by far the most comprehensive. Its great impact was due in part to its forthrightness and its timing. In effect, the report declared a crisis in "Native Alaska" and called for immediate and sweeping changes in health program emphasis in the Territory. Only full Federal, Territorial and local cooperation would begin to meet the great health needs of the people.

Although the *Report* was not responsible for the transfer of health services for Indians to the Public Health Service, its findings were strong

* The *Yukon Health* in later years became a floating restaurant the "Boatel" in Fairbanks. It was destroyed by fire a couple of years ago.²²

* "Inside that quonset was a strange medical center. Patients were jammed together, children underfoot, the strong odor of native-tanned furs and fish permeating the air. In the small treatment room, one lone doctor treated patients and pulled teeth"¹².

* The highlights of this and other surveys will be outlined in the second part of this paper.

medicine in the Congressional hearings then in progress on such a change at the national level. As a result of these hearings Congress passed legislation in late 1954 providing that all health facilities and services of the Bureau of Indian Affairs (including ANS) be transferred to a newly created Division of Indian Health within the Department of Health, Education and Welfare on July 1, 1955.

The Public Health Service was not new to the problems of the Alaska Native. The early health surveys of Drs. Hasseltine, Krulish and Watkins were all sponsored by the PHS. The Revenue Marine Cutters and later the Coast Guard Cutters carried PHS medical officers and many served the Natives when in port. For many years the ANS Health Director in Juneau was a PHS officer on loan, as was the Territorial Tuberculosis Control Officer. Even a few of the field physicians under the ANS, notably Dr. E. S. Rabeau* of Kotzebue, were PHS officers on loan.

THE DIVISION OF INDIAN HEALTH — A NEW DEPARTURE

The transfer was effected smoothly during the summer of 1955. No dramatic changes in staffing or policies were immediately apparent, despite the fact that the Bethel and Kanakanak Hospitals both acquired a new Medical Officer in Charge.

At Bethel the new Director was Dr. Harriet Jackson,* who carried an extremely heavy load for a while as the only physician in the newly-opened hospital. Dr. Jackson remained with the PHS for several years before taking a position with ADH as a field physician for the McGrath Project, a research study on the causes and prevalence of middle ear disease. In 1959 she opened a private practice in Bethel and subsequently was elected mayor of the city. She remained on the lower Kuskokwim until 1965 when she departed for private practice in Livonia, New York.

Shortly after the new Bethel hospital had opened its doors in 1954, some interior remodelling was found necessary. What had been designed as an isolation ward for tuberculosis was converted into an outpatient clinic and administrative space, since the PHS was able to send most tuberculosis patients to the new 400 bed hospital in Anchorage or to other contract facilities. In 1963 another major renovation occurred when the hospital acquired a new front wing to provide space for medical records, a waiting room and new clinic facilities.

* Dr. Rabeau later became Assistant Surgeon General and Director of the Indian Health Service in Silver Springs, Maryland.

* Since married, Dr. Harriet Jackson Schirmer now practices in Wrangle.

The Kanakanak Hospital meanwhile was also undergoing change. At the time of the transfer, two large quonset huts were still being used for the inpatient care of tuberculosis, but within a few years one had been converted to staff quarters and the other to an outpatient clinic, offices, laboratory and x-ray.⁷

The first PHS physician at Kanakanak was Dr. George Wagnon, who remained four years before transferring to Bethel in 1959. *

As soon as the Public Health Service was able to secure more adequate appropriations from Congress, the scope of health services for the Alaska Natives gradually expanded. Recruitment of scarce health professionals became considerably easier now that physicians, dentists, pharmacists, sanitarians and trained hospital administrators were able to fulfil their two-year military obligation as Commissioned Officers in the PHS. Though most were young and remained in the field for only two years, they were a new breed — vigorous, well-trained and for the most part strongly motivated.

The hospitals were changing their nature. From facilities designed for the long term care of tuberculosis and the inpatient treatment of acute emergencies, they were now becoming short-term general hospitals with a strong emphasis on obstetrics, outpatient care and field activities.

Medical visits to the outlying villages were not new, having begun with the early Bureau of Education hospitals. As the hospitals grew in size and responsibility, however, the single doctor found it difficult, as well as an unproductive use of his time, to absent himself except under unusual circumstances. Once the staffing pattern improved in the late 1950's, the PHS gave renewed emphasis to field visits as a way of providing some preventive services. At first only a selected few villages were visited regularly, perhaps six times a year, while the remainder received no direct services at all. In more recent years, however, the medical staff has made an attempt to visit each village at least once a year. High risk villages receive more intensive followup.

On village trips the doctor carries his "field gear", consisting of several metal chests filled with drugs, supplies, eye charts and diagnostic instruments. His mode of travel nowadays is usually ski- or float-equipped light aircraft, although sometimes he may visit the closer villages by boat, snowmobile or even (within recent memory) dog-team. A trip may last one or two weeks and include three or more communities. During his stay in the village the doctor works long hours, usually in a school room or a clinic building.

* Dr. Wagnon later served as Director of the Mt. Edgecumbe Hospital and is at the present time Chief of the Office of Program Services, Alaska Area Native Health Service in Anchorage.

He often sees patients well beyond midnight and it is not uncommon for more than one hundred patients to have registered in the 24 hour period. The day's work includes eye refractions and dental extractions, in addition to care of routine cases of respiratory illness, draining ears, minor accidents, prenatals and the inevitable aches and pains.⁶

Radio medical traffic is a well-established but still evolving feature of medicine in all the remote areas of Alaska. It began at least three decades ago when the Bethel and Kanakanak Hospitals were still under the administration of the Alaska Native Service.^{7,19} Everynight the doctor held a short-wave radio "sched" with each of the BIA schools in the outlying communities. Every type of illness, sometimes described in the most intimate detail, was discussed over the airwaves. Although initially the hospitals talked only with BIA schools, in more recent years the doctors have on occasion been in touch with State Schools, canneries, airline offices, ships at sea, aircraft in flight, National Guard posts and offshore islands. The advent of inexpensive battery-powered receivers added a new dimension by bringing the "doctor's sched" into many Native homes where the opportunity for health education was immediately apparent.

Some concept of the extent to which radio call is utilized today in southwestern Alaska may be gained from a special study of the Bethel-Hooper Bay traffic in 1966. In that year there were 242 separate contacts and 515 different illness episodes reported, an average of 0.96 per person in the village.⁶

Since the late 1950's various types of local health aides have played an increasingly important role in the provision of health services to the outlying villages. Some of the earliest ones were community residents, usually women, who were employed by the Arctic Health Research Center as "chemo aides" during the massive ambulatory chemotherapy program of that period. Others became known as "medical aides" and were informally trained by the local hospital with on the job experience under the ADH public health nurses. These individuals began by supervising long-term medications, particularly isoniazid, providing first aid, carrying out post-hospitalization instructions and assisting the doctor or nurse on their field trips. Gradually the aides took over from the school teachers the crucial role of reporting illnesses on the radio. Most held a daily "sick call" at the clinic or school.

By 1964 the PHS recognized that these aides needed more formal training in view of the increasingly important responsibilities they were assuming. In the spring and again in the fall of that year, the staff of the Bethel Hospital developed and presented a training course at which some 30 aides were given a two week intensive and

structured program of training experience. A similar course was again presented at Bethel in the winter of 1967. Since that time, the training of medical aides, now called Community Health Aides, has assumed considerable importance throughout Alaska. Beginning in 1968-69, the aides were given an intensive two-week training course at the field hospital, then three further weeks at the Alaska Native Medical Center in Anchorage. In some cases a week or two of further experience was then provided at Bethel or Kanakanak before the aides were on their own in the community. Through special funding from Congress the PHS has also recently been able to provide payment for the aides, either by direct contract with the individual or the village council, the predominant pattern in the Kanakanak Service Unit, or through a contract with the Association of Village Council Presidents in the Bethel Service Unit.^{18, 21} As of January 25, 1971, 115 Community Health Aides were on duty in southwestern Alaska, including 88 in an employed status.

The Community Health Aides have become the keystone of the whole field health program in Alaska. In addition to the more traditional duties outlined above, the aide dispenses medications on the doctor's order, keeps the village drug supply current, maintains medical records and acts as the village spokesman on health. He or she also serves as the liaison between the PHS hospital and the village council. For over 10 years some of these aides have worked long hours without pay, with minimal training and in some cases with little recognition. Now, belatedly, these conditions are changing for the better.

Along with an appreciation of the scope of the health problems generally during these years came an increased awareness of the importance of the environmental problems. In the late 1950's the Alaska Department of Health had inaugurated in the Bethel area a program to train and employ village Sanitation Aides. These men, all Natives, advised villages on such problems as water supply and waste disposal, and on insect and dog control measures.¹⁰ Parallel to this activity the Arctic Health Research Center during this time was carrying out basic research studies on problems of environmental health in relation to permafrost and low temperatures.

In the early 1960's the Division of Indian Health, under authority of Public Law 86-121, began assisting certain villages with the provision of safe water supplies. The PHS made available materials and equipment and designed the facilities, while the village in turn provided assistance during the construction phase. Maintenance of the system was the responsibility of the village, with technical support from the PHS. Progress of this program has been relatively

slow because of the short construction season and other logistical difficulties, but gradually environmental conditions are improving. By September 1970, approximately 4000 persons in 21 villages in southwestern Alaska had been provided with watering points and individual waste systems, or with community water and sewer systems under this program.²¹

In 1965 a PHS sanitarian was assigned for the first time to the Bethel hospital, his service area covering both the Bethel and Kanakanak regions. His responsibilities included hospital sanitation, overseeing the PL 86-121 projects under construction, and supervising the Village Sanitation Aides, the latter program having by now been transferred from ADH to the PHS. In the summer of 1966 the environmental health program at Bethel acquired a boat for use in transporting construction supplies along the Kuskokwim. Since then several medical field trips as well have been made by boat to the small fish camps and hard to reach villages along the river.

THE INDIAN HEALTH SERVICE TODAY

Before leaving this brief account of IHS activities in southwestern Alaska, it might be helpful to summarize the current facilities and recent workload trends.

The Bethel Hospital is now rated at 42 beds, that being the amount of space available according to the Standards of the Joint Commission on Accreditation of Hospitals. Because of the heavy workload, however, an inpatient census has been recorded as high as 90 on occasion in recent years. The staff consists of 107 persons, including seven physicians. The hospital received full three-year accreditation on its survey in June 1966, reflecting that the quality of medical care being rendered was comparable to that in any small hospital in the nation.

The Kanakanak Hospital is currently rated at 38 beds and its staff consists of 47 persons, including two physicians. The facility, not being of fire resistant construction, does not qualify for accreditation at this time.

In recent years, the PHS was constructed village clinics at Hooper Bay (1966) and Alakanuk (1969). These are self-contained facilities which include temporary living quarters for visiting health professionals. In addition to its own clinics, the Service leases space at St. Mary's on the Yukon, and at Ekwak, New Stuyahok and Manokotak in the Kanakanak Service Unit. All these clinics are utilized not only by the health personnel who visit the village but on a day to day basis by the Community Health Aides.

Communications have greatly improved in recent years. The PHS has recently installed single

sideband equipment in all its own facilities. Almost every community now has the capability to contact the hospitals through some means, either by telephone or through a BIA, State or privately owned radio. Twenty-one villages have an emergency crystal available in their sets.²¹

Current workload levels reflect the extent to which the people of the region utilize their health services. In Fiscal Year 1970 the Bethel Service Unit had a hospital discharge rate of approximately 150/1000 population, compared with a figure of about 210/1000 for the Kanakanak Service Unit. The average daily census at Bethel was 38.5 and at Kanakanak a little over 13 during FY 1970. These latter figures are somewhat lower than in recent years, probably reflecting the gradually improving health conditions and the fact that more adequate care is available in the outpatient clinics and in the villages. In the period 1965 to 1970 the outpatient load increased by 130% at Bethel and by about 9% at Kanakanak. During the same period the field visits were up 75% at Bethel and by 37% at Kanakanak.²¹

In 1966 a study at Hooper Bay revealed that 16.3% of village residents were admitted to the hospital during that year, with the highest rates, as might be predicted, among the infants and elderly. In that year PHS physicians made four trips to the village, during which they recorded 791 patient contacts, some 1.5 per person. The people of Hooper Bay also utilized the radio extensively, as pointed out above.⁶

OTHER AGENCIES AND PROGRAMS

Several other agencies and programs deserve brief mention for their contributions to the health services available in southwestern Alaska.

The Arctic Health Research Center has been mentioned a few times already in this paper. Set up in the late 1940's as an agency of the Public Health Service, the Center has maintained a Field Station of its Epidemiology Section at Bethel since 1954²³. Many fine research studies, particularly in ambulatory chemotherapy and chemoprophylaxis of tuberculosis, otitis media and infant mortality, have been carried out in the Bethel Service Unit. In addition to the research activities, however, the staff have always given freely of their time in the villages to provide emergency medical care, give immunizations, train aides and make referrals to the hospital. For years the research nurses, known to the villagers as "chemo nurses" for their participation in the isoniazid studies of the late 1950's and early 1960's, have been well accepted by the people.

The volunteer nurses at the St. Mary's Catholic Mission have also provided village nursing care to the people of the lower Yukon region for a

number of years²⁴. A similar situation has prevailed at Anvik and the surrounding Indian villages of the middle Yukon. Here the Episcopal Mission has had at least one nurse on their staff off and on for over 50 years. From time to time other nurses also, mostly teachers or teachers' wives, have volunteered their services unselfishly in the villages in which they lived.

In the Bristol Bay region certain limited health services have been provided for years by physicians or nurses employed for the fishing season by some of the large salmon canneries. Since most of those who now work for the canneries are Natives either from the Kanakanak or Bethel Service Units, this extra source of medical care has sometimes had a measurable impact on the utilization of services in the region.

The Bethel Prematernal Home, or *Kingalret Witaviat*, as it is known in Eskimo, is a unique institution which deserves mention because it is a monument to community cooperation. For years prenatal patients from the outlying villages had come to Bethel from one to four weeks before their anticipated date of delivery because of the uncertainty of travel or because of some health problem. Usually these women could not be accommodated at the hospital because of lack of space and therefore were expected to live with relatives, friends or even strangers in the town. Most slept on a cold floor and got very little to eat, with some even paying for the privilege. In 1965 several residents of Bethel, notably Dr. Harriet Schirmer (nee Jackson) and Mr. Bob Mulcahy, conceived the idea of a residence for these women. By the winter of 1966-67, the city had donated a building and the OEO and PHS had provided funds for a staff, including an Eskimo registered nurse as Director. The Home was an immediate success, providing pleasant living accommodations for about fifteen women. Prenatal care, including transportation to and from the hospital, and a program of health teaching were provided jointly by the PHS and the staff of the Home.

The Office of Economic Opportunity Healthright Project, initiated in 1969, is the newest venture into the health care field in the region. This program, which is funded through the Alaska Federation of Natives, Inc. by OEO, is operated by the Yukon-Kuskokwim Health Corporation based at Bethel. Its major purpose is to provide supplemental health services while involving the consumer in the planning and carrying out of the operation itself. The Corporation is a policy board which draws its membership mainly from the Native people of the area, although it also has representation from the PHS, ADH, the State Medical Society and other Federal, State and local agencies. The current grant totals \$816,000 and includes components such as basic and advanced

training of Community Health Aides, a pilot Community Health Representative program, sanitation activities, social services, renovation of village clinics, a dental program and support of the Prematernal Home²¹.

Finally a word should be said about the health services available to the non-Native people of southwestern Alaska. Since this is largely a transient group, their health problems primarily reflect their own personal backgrounds, although all are also subject to the dangerous environmental conditions the Natives face. The primary resource for these people has been the private practitioners or cannery doctors who have sporadically been available. Government physicians have always treated non-Natives for emergency conditions to the extent their time and facilities permitted, although they have been hampered by regulations denying the provision of routine care. In 1966 a bill was passed by the Alaska State Legislature and a similar one by the U. S. Congress authorizing non-Natives to be treated on a routine basis in PHS hospitals in remote areas.

SUMMARY

I have tried to trace in this paper the growth of health services to the people of southwestern Alaska. From the crude beginnings under the Moravian missionaries, less than 80 years ago, great progress has been made toward the goal of bringing the benefits of modern medical science to all the people. Today many organizations and agencies, — federal, state and local, official, private and charitable — cooperate in this endeavor.

Much of course remains to be accomplished. Some of the most serious health problems of this area are intimately bound up with poverty, housing, sanitation, water, waste disposal, transportation, communications, diet and education. Progress is being made, albeit slowly, in all of these areas, although some of these problems are beyond the traditional scope of health agencies. Other problems are tied to factors less amenable to change, such as isolation, a rigorous climate, and the hazards of living and working in a rugged land.

The health of the Native people of southwestern Alaska remains poor. The Yukon-Kuskokwim Delta area especially still has the highest tuberculosis rates and infant mortality anywhere in Alaska and one of the highest in the nation. Medical care is terribly expensive in such an area, and though it is essential, it will not of itself lead to a significant improvement in health conditions. Only more resources directed toward disease prevention, health education and sanitation in the health field, and toward better housing, transportation, communication and family income in the economic field, will lead to progress in this region where truly the people are the wealth of the land.

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IN WHICH ARE INCLUDED SOME PROPOSALS FOR THE ALASKA NATIVE HEALTH SERVICE

By Paul Eneboe, M.D.

Based on Bush Medicine Committee Proposals

GENERAL AND STATE-WIDE CONCEPTS AND SUGGESTIONS

The Alaska Native Health Service is not bound by law to the comprehensive health planning mechanism. In Alaska, the Alaska Native Health Service personnel have made a concerted effort to work in concert with comprehensive health planning activities. However, until such time as comprehensive health planning has true jurisdiction over the Alaska Native Health Service program, they will have no real effect on the direction and implementation of these programs. We therefore make the following suggestion: That the Federal government require that all federal health programs be subject to the state comprehensive health planning body and that in local areas federal health programs be reviewed and approved by the local CHP agencies.

The Alaska Native Health Service has made a real effort to increase local input. This has been done primarily through local native boards of health. Since in many areas the Public Health Service facility serves many people in addition to Alaskan Natives, the hospital boards should include representation from the non-native consumers.

These boards should have a more powerful position, with authority over personnel, funding, budget decisions and program planning. In fact, they should direct or run the hospital.

In some communities where Alaska Native Health Service facilities are in competition with local community facilities, the local community health facilities frequently suffer. In these areas, serious consideration should be given to the withdrawal of the Alaska Native Health Service facility. A reassessment and redirection of contracting policies is needed. In many cases the use of contract medical care can sharply upgrade services in that community and improve the quality of medical care for all.

Recognizing that the Alaska Native Health Service has examples of abuse of contract funding, a peer review system should be established, utilizing both contract and non-contracting individuals to assure competent care at reasonable cost.

The impetus of contract funding should be changed from that of fee for individual service to purchasing a block of services and should include increases in preventive health activities. The imaginative and creative use of contract funds could have a significant influence on upgrading the role of the contracting private physicians and hospitals.

The present mechanism of funding for many items in the Public Health Service (line item) restricts local decisions and markedly inhibits local responsiveness of the health service system of the Alaska Native Health Service system. We urge that the Washington level of the Public Health Service greatly increase local autonomy and authority.

The steady supply of competent physicians induced to join the Public Health Service by the attractions of the draft is not assured. The time may come when the Alaska Native Health system is short of physicians. Against this day, the Public Health Service or the Alaska Native Health Service should develop a system utilizing the competent paramedical persons now emerging, such as those trained by the Medex program in Washington. Even now these para-professionals can provide a significant block of care to many areas in Alaska. The Alaska Native Health Service should work with the newly formed Health Manpower Commission to develop such services, not only for Alaska Natives, but for all citizens.

SOUTHEASTERN ALASKA

The practice of transferring native patients from community hospitals such as Ketchikan or Juneau should stop. Care should be provided Alaska Natives in their home community.

The Mount Edgecumbe Hospital is a white elephant and should either be closed or converted into a different type of facility, perhaps psychiatric, chronic care, or both. The Mount Edgecumbe Hospital might well be given to the State, or even wiser, demolished.

The community of Sitka needs a new hospital. A new facility should be constructed in Sitka with Alaska Native Health Service support, utilizing PH 151 funds in the same manner as was done for the Fairbanks and Juneau hospitals.

The Public Health Service should continue to provide field health services, but where feasible should contract for preventive or field health services with willing local physicians.

By changing its undercutting role in Southeastern Alaskan health care developments, the Alaska Native Health Service would stimulate an influx of specialists and allied professionals to local communities, benefitting all people in the area.

TANANA SERVICE UNIT — FAIRBANKS

There is not sufficient input into the Bush Medicine Committee from the Fairbanks area to make an informed, detailed comment on the Tanana Service Unit. The Fairbanks Medical Society has appointed a committee which will submit a report of their suggestions at a later date. The members of the Bush Medicine Committee do, however, feel that two points should be made. One: that Tanana is no longer the logical center for Public Health Service activity in the Northcentral area of Alaska. These activities should be moved to Fairbanks. Second: that to the fullest extent possible, the Public Health Service should utilize Fairbanks community resources and should avoid duplicating existing facilities in Fairbanks.

BARROW SERVICE UNIT

In Barrow, the Public Health Service adequately provides the needed medical and health service. It would seem that the hospital board should include non-native as well as native representation, since the Barrow Hospital is a community hospital and Barrow does have a mixed population.

KOTZEBUE SERVICE UNIT

The excellent hospital at Kotzebue is underutilized, and its utilization should be increased by providing more services locally such as increasing the frequency and scope of surgical and other clinics.

The community of Nome is in the Kotzebue Service Unit. It has been evident for a long time that private medicine is unable to provide adequate care for the Nome community. The Public Health Service should either take over and run the Maynard-McDougal Memorial Hospital or should construct a more adequate facility to provide health services for the community of Nome. If the Public Health Service is to provide a community hospital, the hospital board should be representative of the Nome population and have non-native representation. With the hospital fully open, services could be provided to all patients through either private or public professionals.

BETHEL SERVICE UNIT

The most urgent and first priority for Public Health Service construction in Alaska should be a new hospital for the community of Bethel. The current hospital is antiquated and inadequate.

A large percentage of the surgical patients at the Alaska Native Medical Center in Anchorage come from Bethel. The new Bethel hospital should be constructed to provide surgical services to the Yukon-Kuskokwim Delta. In addition to a surgeon and his supporting staff, the hospital should have at least an internist and a pediatrician as well as the necessary complement of general medical officers. Careful evaluation should be made to determine whether additional specialists such as otolaryngologist, gynecologist, or ophthalmologist are warranted in the Bethel area.

In planning and constructing a new hospital, care should be taken that the hospital and quarters, as well as the supporting staff, are adequate to attract competent physicians and health personnel to remain for extended periods of time in the Bethel community. If a well-planned, adequate hospital is constructed, along with pleasant living and recreational facilities, many of the problems of constant turn-over will be reduced, if not eliminated.

With the changing role of an increased medical facility at Bethel, the planned health centers at Aniak and St. Mary's should be carefully re-evaluated. It may be that with a large facility in Bethel and an increased field health program, the stationing of a physician in Aniak and St. Mary's will not be warranted. Or it may be that their need will be increased. In either event, the needs of the entire Yukon-Kuskokwim Delta, indeed, of all Southwestern Alaska, should be carefully considered in planning for a new Bethel hospital.

KANAKANAK SERVICE UNIT

The hospital at Kanakanak represents an untenable situation where a private physician in the community is prohibited from practicing in and utilizing the community hospital facilities. The Kanakanak Hospital, like all Public Health Service hospitals in Alaska, should be opened to all patients and all physicians.

ANCHORAGE SERVICE UNIT

The stationing of a physician on the Pribilof Islands may no longer be justified in view of the continuing and increasing health manpower shortage. A competent, appropriately trained paramedical person, such as a Medex, can provide equal, if not better health services.

The Alaska Peninsula and the Aleutian Chain represent an area almost completely uncovered by

health resources. With good reason, many communities on the Chain and the Peninsula are actively seeking a physician. For equally valid reasons they are unable to attract or hold one. This area represents an ideal situation for paramedical medical and health care. In this region the Public Health Service should work closely with the Health Manpower Commission and the local communities to develop a system for providing services to all people on the Peninsula and Chain without regard to racial background.

Kodiak represents another community where local medical development has been hampered by the practice of transferring out hospitalized patients. The Public Health Service should stop transferring patients to Anchorage except when medically indicated, and should utilize the Kodiak medical facilities to provide all of its services, including preventive and field health in the Kodiak area.

On the Kenai Peninsula, the Alaska Native Health Service should support and utilize local health facilities except when transfers to Anchorage are medically indicated. Some of the communities have the services of visiting specialists. The services of these specialists are denied to Alaska Natives even though these self-same men may be consultants to the Alaska Native Health Service hospital in Anchorage. The talents of all professionals should be available to the Alaska Native, guaranteeing an equality of access to all health services.

ANCHORAGE

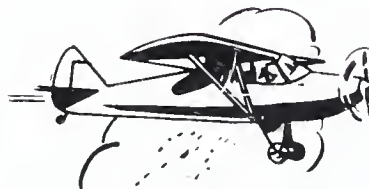
The Alaska Native Medical Center in Anchorage, should, like all Alaska Native Service hospitals, be opened to all qualified physicians.

Any future planning or construction undertaken in the Anchorage area should be combined with and in concert with one of the existing private medical facilities, because of the multiple benefits to health care and the savings resulting from shared staff, facilities, and equipment.

SUMMARY

In summary, we propose the following changes to The Alaska Native Health Service.

1. Stop transferring patients out of local communities.
2. Provide care in local communities by contracting.
3. Contract for preventive health as well as general medical services.
4. Develop a peer review system to assure responsible contract costs.
5. Close the Mount Edgecumbe hospital.
6. Move the Tanana Hospital activities to Fairbanks.
7. Build a hospital in Nome or take over and run the Maynard-McDougal Memorial Hospital.
8. Build a new hospital at Bethel with surgical and allied capabilities.
9. When constructing hospitals and facilities in rural areas, plan attractive living and recreational facilities.
10. Open hospitals to private physicians.
11. Develop a paraprofessional program.
12. In areas where Public Health Service facilities are the only health resource in the community, non-natives should be included on the hospital boards, and the boards given the power to run the hospital.
13. In these areas, all services should be available to all people.
14. In Anchorage, construction of any new facilities should only be in conjunction with existing or planned community hospitals to avoid perpetuating present inadequacies and duplications.
15. Comprehensive health planning should have control and jurisdiction over Public Health Service programs and should work to develop a system of health care delivery that assures equality of access to health services to all persons.



IN SEARCH OF A PLOT

By Banquo

The following is a true incident which occurred in the practice of one of our fellow practitioners. Only the names and date have been changed to protect the innocent? To add a sense of drama the patient's condition was altered slightly but not much. At first glance the transaction seems exaggerated. But it is not, as any physician who has made similar referrals can attest.

CAST OF CHARACTERS

Cornelius Strongheart Patient
Mrs. Stumpf Cornelius Strongheart's sister
G. Willis Bezor, M.D. A physician in his own employ
Miss Amplechest Dr. Bezor's secretary
Miss Wellwiggle Dr. Bezor's nurse
Dr. B. S. Loud Director of V.A. Admin. Juneau
(V.A. of course stands for venerated agrarian)
Mrs. Lex Dr. Loud's secretary, Juneau
Mrs. Aleshine Dr. Loud's secretary, Juneau
Mr. H. C. Betzless A V.A. employee in Anchorage
Dr. Polstrate A specialist at the Elmendorf Hospital
in removing stuck knives
Sgt. Snorkel A sergeant
Airman Obtuse An airman
Plus a supporting cast of thousands — clerks, secretaries,
airmen, sergeants, captains, telephone operators, ticket
agents and airplane pilots.

Our play opens in Dr. G. Willis Bezor's quiet office in a small community in Alaska. An off-stage knock is heard and on walks Cornelius Strongheart dowdy member of the Grand Army of the Republic, who in demonstrating Picket's charge to his nephews, stumbled and fell on his sword, which is now lodged in his left chest traversing the left ventricle and affixing it to the spine. With such force did the good Strongheart inpale himself that he is unable to dislodge the offending implement and has come to his good friend, Dr. Bezor, for assistance. Dr. Bezor grabs the trusty saber and pulls mightily but finds he is unable to dislodge it. Wisdom dictating the course, Dr. Bezor elects to send his patient to the great hospital in Anchorage where a more qualified specialist can remove the vile weapon.

Dr. Bezor concludes that a phone call will hasten matters toward curing his patient and sets out to smooth his travels. This being the first day of the month, and a Monday to boot, Dr. Bezor

hums in confidence, knowing he will have no difficulty getting his patient transferred to the large medical center which takes care of this type of problem. But alas, it is not to be so simple.

At last Dr. Bezor is connected with the Elmendorf Hospital and explains briefly the nature of his problem and asks for the appropriate department which is of course, the Department For The Removal of Stuck Civil War Swords. Told indignantly that no such department exists in this hospital, despite the fact that it is common in other hospitals, Dr. Bezor persists in his quest. He is finally given three numbers and told to ask for Dr. Polstrate, who is known to have solved this kind of problem before. Drawing a blank on the first two numbers, Dr. Bezor is finally connected with Dr. Polstrate who agrees that it is a most interesting case that wants his personal consideration and endeavor. Dr. Polstrate states that he will take care of all matters on that end and that Dr. Bezor should send the patient forthwith. They agree that due to traveling arrangements it would be best if the patient traveled on the next day.

On Tuesday the second day of the month, Dr. Bezor placed a call to Dr. B. S. Loud in Juneau and informed Dr. Loud of the unfortunate situation and of Dr. Bezor's discussion with Dr. Polstrate and that Dr. Polstrate felt that transfer to Anchorage was most definitely indicated and that arrangements were needed to transfer the patient to the Elmendorf Hospital. Dr. Loud concurred and wished the patient a pleasant voyage. That same day Miss Amplechest placed a call to the Elmendorf Hospital. She was connected to Sgt. Snorkel, who listened sympathetically as Miss Amplechest explained the necessity for travel arrangements. Sgt. Snorkel then referred the call to Airman Obtuse to whom Miss Amplechest again explained the necessity of transferring our good patient to Anchorage. Airman Obtuse stated that he must check first with Juneau to authorize the transportation and Miss Amplechest then gave Airman Obtuse the pertinent information such as the date of appointment, the type of examination, the doctor involved and the patient's name. Airman Obtuse said that he would check with Juneau and call back forthwith.

On the third day of the month, no call arriving from Airman Obtuse, a call was placed by Dr. Bezor's secretary, Miss Amplechest. Airman Obtuse being out of the office, the call was

referred to Sgt. Snorkel, who referred Miss Amplechest to the Anchorage V. A. The Anchorage V. A. was called, the situation was explained and they referred Miss Amplechest to the federal V. A. The federal V. A. was called and a Mr. H. C. Betzless was obtained, a most sympathetic and helpful gentleman, who listened carefully as Miss Amplechest and Dr. Bezor explained the problem which was simply that someone needed to obtain an airline ticket for the goodly patient. After listening carefully, Mr. Betzless agreed that things had indeed been stretched slightly and stated that he would make all necessary arrangements and apologized profusely for the red tape. The next day Miss Amplechest dropped in to see Mrs. Stumpf, the patient's sister, and confirm the arrangements, where upon Mrs. Stumpf notified Miss Amplechest that the appointment in Anchorage had been changed to 11:00 a.m. of that day and since the plane left at 4:00 p.m. he would be slightly late for his appointment and since no ticket had arrived, Mrs. Stumpf asked Miss Amplechest if she could change Mr. Strongheart's appointment to a later day. That same day Miss Wellwiggle, Dr. Bezor's office nurse, called Dr. Polstrate at Elmendorf Hospital. Dr. Polstrate was most accommodating and agreed to change the appointment to two days hence to accommodate our patient and the airline schedules. However, a slight interruption occurred in the play. The four, fifth and sixth days of the month being a holiday at the Elmendorf Hospital, Dr. Bezor and his staff were unable to contact anyone with any information.

The day of Mr. Strongheart's appointment finally arrived and his sister, Mrs. Stumpf, called Dr. Bezor; no ticket being available and the airline having never heard of the patient. A frantic call placed to Juneau was to no avail since the V. A. offices in Juneau had closed. However, someone who had answered the phone said they were just working briefly but that the ticket would be waiting at the desk at the ticket counter the next morning.

The next morning Mr. Strongheart appears at the ticket counter but no ticket is available. Mr.

Strongheart, wishing to have the offending weapon removed from his chest, elects to pay his own way into Anchorage. Hoping for a reimbursement from the V. A. Administration, he departs the scene. That same day, Miss Amplechest calls Mr. Betzless' secretary at the federal V. A. office in Anchorage and is informed that Mr. Betzless cannot handle or authorize transportation for "Venerated Agrarians" and Miss Amplechest is referred back to Dr. Loud's office. Dr. Loud's office is closed as Dr. Loud has been taken ill and after talking with Mrs. Lex and Mrs. Aleshine the situation is again explained. Apologies are profused and Mrs. Lex and Mrs. Aleshine assure Miss Amplechest and Dr. Bezor that authorization to reimburse Mr. Strongheart will be on the way.

Sequel: The mission accomplished, Dr. Polstrate removes the offending weapon and places the patient, Mr. Cornelius Strongheart on a series of intricate treatments designed to strengthen and heal his left ventricle. Mr. Strongheart being a venerable veteran of Picket's charge has occasional mild lapses in memory, and Dr. Bezor, wishing to continue Dr. Polstrate's excellent regime, drops a note to the Elmendorf Hospital asking for a summary of his patient's treatment and discharge medications. He receives a note stating that such information is classified and that the hospital has no authorization to release any such information to unauthorized persons. After several subsequent exchanges of brief, pleasant notes, accompanied by such documents as request for release of information from the patient, and a three month wait, Dr. Bezor is finally rewarded by an illegible photostatic copy of his good patient's work-up, which he appreciates greatly.

As the curtain closes we see Dr. Bezor sitting quietly in his office playing checkers with his patient, Cornelius Strongheart who is asking Dr. Bezor about his travel reimbursement which has never arrived. Just as the curtain falls an off-stage knocking is heard, and enters J. P. Gildersleeve, who served valiantly in the War of 1812, with an ax buried in his head. — P.E.



MUKTUK MORSELS

By Bob Ogden

JUNEAU

The Juneau Medical Society is working hard on plans for the 1971 annual convention of the Alaska State Medical Association to be held June 9, 10 and 11 in Juneau. Society President DR. BOB CAVITT reminds all to make hotel reservations early and to contact DR. JOHN DALTON, 180 Behrends Avenue, Juneau, for fishing arrangements.

DR. JOHN DALTON closed his practice on April 1. Dr. Dalton will remain in Juneau in part-time practice.

DR. KEN MOSS is moving his pediatrics practice into the office vacated by DR. JOHN DALTON at 555 Willoughby Avenue. Dr. Moss will begin practice in his new office May 1.

KETCHIKAN

DR. DAVID McPHETRES has left California to join DRS. J. MORTENSEN and H. HENDRICKSON in General Practice in Ketchikan. DR. McPHETRES was born and raised in Juneau.

DRS. MORTENSEN and HENDRICKSON are having a new clinic built and hope to have it completed by April 15.

KENAI PENINSULA

Scheduled opening of the Central Peninsula Hospital (32 bed) in the Soldotna-Kenai area is set for February 1. It will be administered by the Lutheran Hospital and Homes Society, Inc., a non-profit organization, for the Kenai Peninsula Borough.

FAIRBANKS

The Fairbanks Medical Association has been aggressively engaging in developing a disaster plan in anticipation of the predicted flood. Their disaster plan was recently published and is a model for others.

DR. MOHAMMAD QURESHI, anesthesiologist, had a new son.

ANCHORAGE

DR. RODMAN WILSON recently returned from a speaking engagement at Johns Hopkins University. Dr. Wilson spoke on mountain medicine and was one of four speakers at his 25th class reunion.

DR. PAUL WORRELL has joined the Anchorage Medical and Surgical Clinic in General Practice.

DR. HOWARD ROMIG has been appointed to the Alaska State Board of Fish and Game.

DR. THEODORE SHOHL and MARY KAY HUNT were married January 30, 1971. Mrs. Shohl is well known to the Anchorage medical community for her outstanding work at the Providence Hospital emergency room. After a honeymoon in Mexico and Hawaii, the couple returned to Anchorage.

DR. PAUL DIAMOND, formerly staff psychiatrist at Alaska Psychiatric Institute, plans to open a private practice in psychiatry at 1455 W. Hillcrest Drive.

DRS. RICHARD and MARIAN WITT of Cincinnati recently bought a house in Anchorage. They will return in August to practice in the Providence Hospital Professional Building. Dr. Richard Witt is currently professor of medicine and director of the pulmonary division of the University of Cincinnati at Cincinnati General Hospital. He will practice internal medicine and pulmonary disease in association with DR. RODMAN WILSON and DR. KEITH BROWNSBERGER. DR. MARIAN WITT is assistant director of Cincinnati Children's Hospital Out-Patient Department. She will practice pediatrics in association with DR. JOHN TOWER and DR. HARVEY ZARTMAN.

DR. SAM GIBSON was appointed to the State Comprehensive Health Planning Advisory Council by Governor Egan.

MRS. J. RAY LANGDON was recently elected President of the Alaska Congress of Parents and Teachers.

DR. and MRS. FREDRICK HILLMAN recently adopted their third son.

DR. and MRS. EDWARD VOKE had a baby girl.

DR. and MRS. MICHAEL HEIN had their third son.



AURORA DENTATUS

JUNEAU MID-WINTER MEETING

Dr. Fletcher Craig School of Dentistry University of the Pacific in San Francisco, presented an excellent course on Operative Dentistry 25, 26 March. Dr. Tom Lewis, Department of Continuing Education, University of Washington is to be congratulated once more for providing us with an outstanding clinician. About

25 men were in attendance, all of whom were impressed with Dr. Craig's sincerity, ability and dedication to quality dentistry.

A very considerable time was spent on Dental Society affairs. President Gerry Morrow is an untiring worker, and assisted by Craig Kauffman, went through a long list of items. Craig will be sending out a condensed account of things done in the near future.

ANNUAL MEETING



Homer — 1971 Convention Site

Homer will be the site of the 1971 Alaska State Dental Convention on June 7, 8 and 9. The pleasant setting of Kachemak Bay and Dr. Ralph Phillips as clinician are expected to make the occasion most informative and pleasurable.

Convention headquarters will be Land's End on the end of the Homer Spit. The nearby facilities of the Light House Inn and the Porpoise Room will also be used. The casual Alaskan atmosphere should provide good vacationing for the whole family.

Dr. Ralph Billings spoke to the 1968 Alaska Dental Society Convention and was so outstanding that he was asked at that time to speak again this year. Dr. Phillips is from the University of Indiana and internationally renowned in the field of Dental Materials.

Dr. and Mrs. Bill Marley, our hosts in Homer, are working very hard to arrange this annual meeting; it promises to be a most outstanding session. Make reservations now. (ED.)

It is unfortunate that the benefits of Surgical Orthodontics are only now being brought forth to practitioners outside the circle of oral surgery. With the publication of the latest journal of the ADA devoted entirely to this subject, many dentists in general practice have now become aware of help for the patients with Maxillo-mandibular disharmonies that would have gone untreated in the past.

It is also timely that the oral surgeon make known his surgical capabilities to the physicians and surgeons who are

in an excellent position to refer the patient with a jaw deformity in for help.

The following article is written by Don Chiles D.D.S. an oral surgery resident in Houston, who will be coming to this area in July to set up practice. It is hoped that this paper will stir up interest in Dental and Medical circles for increased information regarding the current Alaskan availability of help for the patient with a jaw deformity.

Bryan A. Saario D.D.S.

CORRECTION OF SEVERE MAXILLARY-MANDIBULAR DEFORMITIES

**By Donald G. Chiles, D.D.S.*
John N. Kent, D.D.S.****

INTRODUCTION

In recent years a variety of surgical techniques have been described for the correction of dental and facial malformations.^{1,2,3,4,5} In the past, malformations were corrected principally by surgery on the mandible, and in most cases the final result was dependent upon the success of a single operation. Today, the surgeon has at his disposal a number of biologically sound procedures in both the maxilla and the mandible for correction of deformities. It is not uncommon for a patient to receive corrective surgery on both jaws under a single general anesthetic.

Determination of the discrepancies between the maxilla and the mandible and between the dental arches is based upon the clinical evaluation, a cephalometric analysis, and examination of the dental casts. In most instances surgery is based and then planned as to the etiology or location of the discrepancies. Surgery is, therefore, performed in that area where disturbances in growth initiated the deformity. Occasionally, however, it is not possible to operate in these areas, and the correction of the deformity is made in that area which offers hope for the most improvement using the least complicated treatment plan. With this philosophy in mind, a case report of a middle aged adult is described in which a maxillary osteotomy was performed for the correction of severe maxillary protrusion and the sliding oblique horizontal osteotomy of the mandible was performed for correction of a retrognathic mandible.

CASE REPORT

A 35-year-old negro male was referred to the Oral Surgery Service by the General Surgery Service at the Veterans Administration Hospital in

Houston, Texas. The patient was recovering from surgery for an intestinal obstruction with gangrene of the distal ileum secondary to a previous gunshot wound. He was described by the referring doctor as being simply "ugly". (figs. 1 & 2) Examination revealed a gross malocclusion with multiple carious lesions, absence of mandibular molars and extrusion of maxillary molars. Oral hygiene was very poor, and the patient was obviously troubled by the gross discrepancy between the dental arches. He had resigned himself to eventual extractions and construction of dentures in hopes of improvement of the facial appearance. Physical examination was not remarkable on this six foot, six inch male, and the examining physician professed hope that some improvement of the facial appearance could be obtained. Study impressions, periapical x-rays, panorex, and cephalometric study were taken for evaluation of the deformity. The patient was seen by the general dentist, the periodontist, and the prosthodontist. All of the consultants agreed that unless present conditions were changed, the majority of the maxillary teeth would eventually be lost and at that time construction of a maxillary denture would improve the patient's appearance and function. They further agreed that if the remaining teeth were properly treated with restorations, gingival curettage, and a maxillary alveolar osteotomy, that improved function would increase the life of the maxillary teeth. It was also felt that extraction of the maxillary teeth would necessitate a radical anterior alveolectomy for

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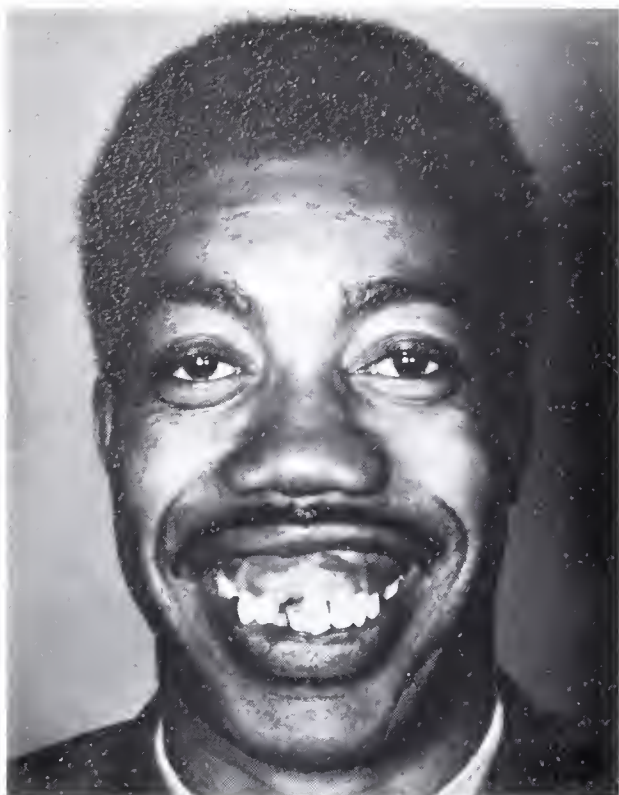


fig. 1

fabrication of the denture, and that if the anterior ridge could be placed in a more favorable relationship by maxillary osteotomy, conservation of the alveolar bone would be accomplished should the patient ever require a maxillary denture.

Cephalometric analysis disclosed a very high mandibular plane to sella-nasion angle of 56 degrees. The pogonion was quite abnormal in position, retruded and inferior. Ideally it was desirable to advance the mandibular body, rotating the inferior border downward posteriorly and upward anteriorly. This would also increase the alveolar interridge space in the molar regions. Examination, however, of the study models would not permit surgery in the mandibular ramus. It was decided to reposition the mandibular symphysis by shifting the pogonion upward and forward by sliding oblique horizontal osteotomy.

Preoperatively, all carious teeth were properly restored. Scaling and curettage was done, and an unsatisfactory anterior cantilever bridge was removed. Study model sectioning through the maxillary second bicuspid regions allowed positioning of the maxillary central incisor, 9 mm. posteriorly and 6 mm. superiorly. Cephalometric tracing of the improved conditions also showed that the soft tissue chin button should be moved at least a full centimeter forward and slightly upward to improve facial profile (fig. 3). An occlusal-palatal splint which contained a plastic lateral incisor was constructed from the mock surgery study models.



fig. 2

	BEFORE----	AFTER —
SNA	82°	79°
SNB	78°	78°
NA to ⊥	25mm	15mm
NB to T	19mm	19mm
⊥ to SN	119°	115°
T to MP	88°	98°



fig. 3

OPERATION

Under satisfactory general anesthesia, using a nasal tracheal airway, the maxillary osteotomy and sliding oblique horizontal osteotomy of the mandible were performed. In the maxilla, the mucoperiosteal flap was created by horizontal incision just superior to the mucogingival junction over the maxillary anterior teeth. The incision was carried vertically downward through the interdental papilla between the cuspid — first bicuspid and then continued around the necks of the teeth, posteriorly to the osteotomy site. The horizontal bony cut was made midway between

the nasal spine and the apices of the anterior teeth. This cut was made below the periform aperture due to the availability of the bone. Vertical cuts through the maxillary second bicuspid regions were made in the usual fashion. The bony cuts were made with the use of the Stryker micro-saw blades and an additional 6 mm. of bone was removed along the horizontal cut. With the premaxilla freely mobilized, the segment was positioned upwards and posteriorly and secured to the palatal occlusal splint without intermaxillary fixation.⁶

A mucoperiosteal incision was then made on the lip side of the mandibular sulcus obliquely downward through the mentalis muscle and periosteum to bone. In the region of the mental foramen, the mental nerves were identified and isolated. Using the Stryker saws an oblique horizontal osteotomy was performed just below the incisors and the mental foramen through the inferior border in the region of the first molar. Much of the genioglossus and mylohyoid musculature was stripped to allow anterior and superior positioning of the inferior border. The inferior border segment was also divided in the midline to achieve a more satisfactory contour posteriorly and laterally. The segments were then fixed to the mandible with transosseous wires. All mucoperiosteal incisions were closed with 3-0 chromic gut and appropriate pressure dressings were placed. Postoperatively there was moderate swelling and some difficulty in swallowing and speaking during the first week. The patient was discharged eight days after surgery, and the maxillary splint removed six weeks postoperatively. The premaxillary segment at this time was noted to be quite firm in comparison with previous maxillary osteotomies in which the horizontal cut is routinely carried to the periform aperture. A bridge was constructed replacing the right lateral incisor and the patient has done well for eighteen months (figs. 4 & 5). As shown in figure 3, a comparison of the pre- and postoperative profile and cephalometric values show considerable improvement.

DISCUSSION

As noted above, an alternative procedure to the maxillary deformity was extraction of remaining maxillary teeth and radical alveolectomy. Due to the patient's age, it was felt that if the anterior maxilla could be repositioned and the teeth maintained for a longer period the ultimate long range prognosis of the ridges would be enhanced. At present the prognosis of the maxillary teeth following the maxillary osteotomy is quite good if the patient maintains improved oral hygiene. If dentures are constructed at a later date, the position of the anterior alveolar ridge will require little alteration in preparation for dentures.

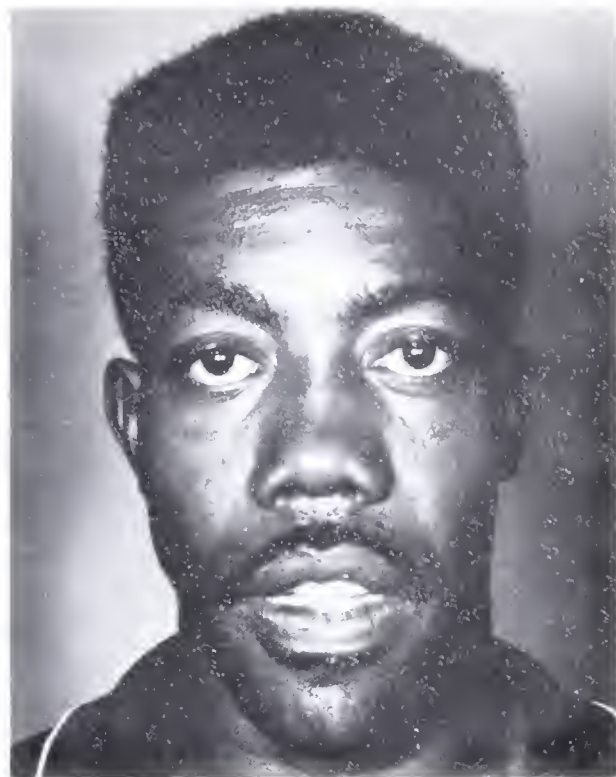


fig. 4



fig. 5

Improvement of the mandibular symphysis by horizontal osteotomy is a very versatile procedure and allows for positioning of the chin not only anteriorly, but superiorly, in which a wedge is removed, and laterally where asymmetry exists.

Due to the tall stature of this patient, shortening of the incisor to inferior border distance was not required. Otherwise, a wedge of bone would have been removed at the time of the horizontal osteotomy.

In most cases, the horizontal cut in the maxillary osteotomy is carried to the lateral periform aperture since the working space between the apices of the incisors and the floor of the nose is not sufficient. Preoperative radiographs of this patient showed an abundance of bone and 6 mm. was removed in this area without jeopardizing the blood supply to the teeth or sectioning the anterior nasal spine.

Of considerable importance is the preoperative oral reconstruction of this patient performed by other members of the dental team. Without proper dental restorations and improved periodontal status, surgery would have either not have been possible or the morbidity of the procedure would be greatly increased.

Combination of maxillary and mandibular surgery should be considered in adults when dealing with severe dental facial discrepancies. A multitude of procedures are available and results need not be compromised by selection of the procedures. Cephalometric studies are helpful in

the location and etiology of the deformity, but should not necessarily dictate the selection of the operative procedure. In many instances, the clinical evaluation and assessment of the study models along with available surgical procedures at the surgeon's disposal will dictate the treatment plan.

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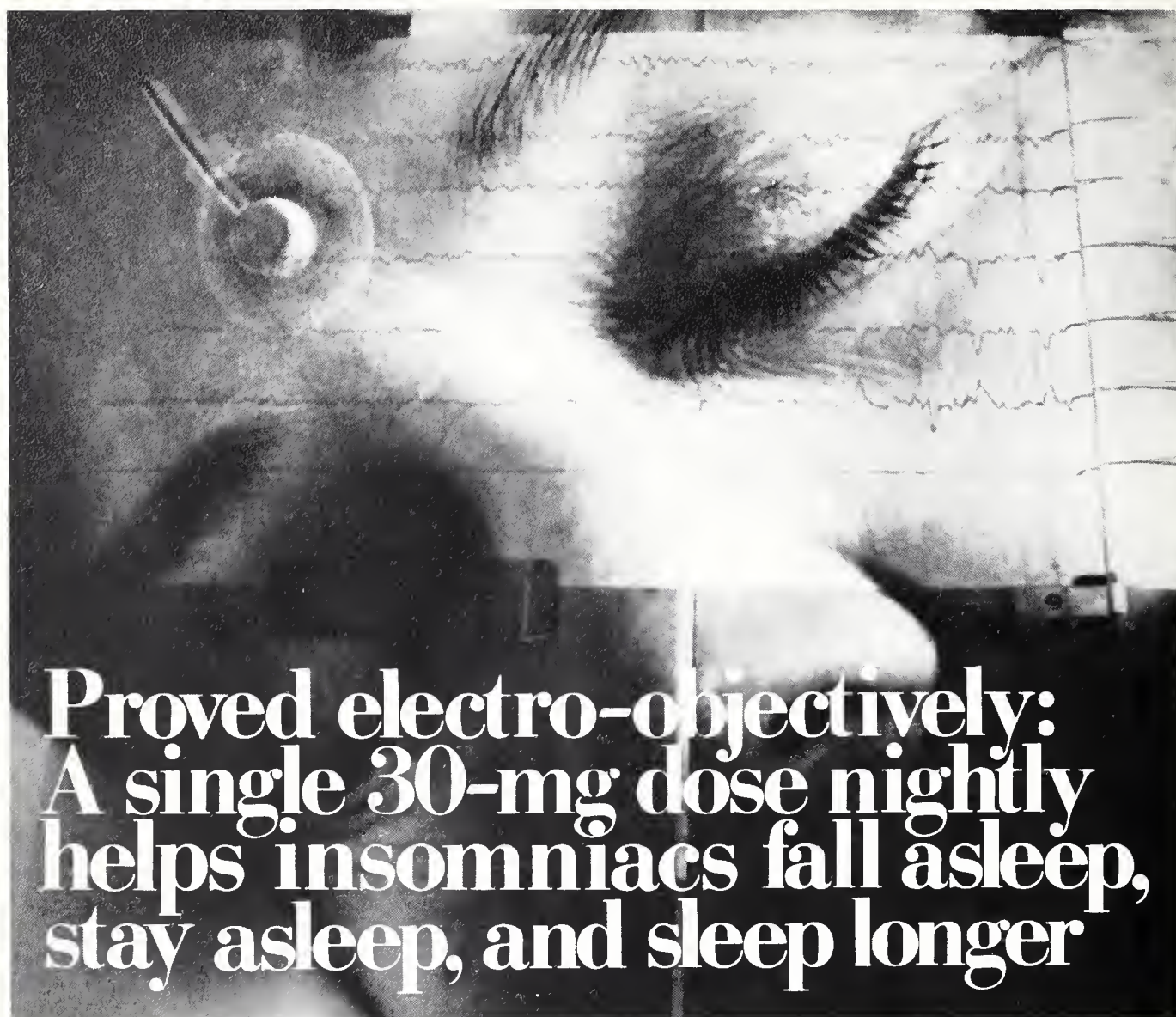
ALASKA Medicine

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Volume 13, Number 3, July 1971





Proved electro-objectively: A single 30-mg dose nightly helps insomniacs fall asleep, stay asleep, and sleep longer

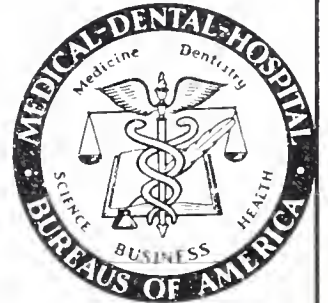
Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.^{1,2,3}

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,¹ Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

Confirmed clinically

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.



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ALASKA MEDICINE



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APPLICATION TO MAIL AT SECOND CLASS POSTAGE RATES IS PENDING AT ANCHORAGE, ALASKA

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Number 3

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LETTERS TO THE EDITOR

MEDICAL LEGAL COMMENTS OR THE DIFFERENTIAL DIAGNOSIS OF DEAFNESS

Dear Sir,

In May-June 1971, a very illuminating lawsuit was staged in Anchorage. Involved were multiple former and currently practicing Anchorage physicians, paramedical personnel, and one of our hospitals. A very large financial settlement was at stake. Nationally prominent medical specialists were recruited as witnesses, and many interesting facets were brought up during this trial. These included both moral issues and medical questions, some of which have not been answered anywhere.

Most fascinating of all, however, was the cool appraisal of what causes a child to be deaf as an isolated finding. A very busy Anchorage pediatrician, who was not fundamentally utilized as an "expert", solved the mystery. This resulted in dismissal of the case.

Briefly, the problem was one of a child born in 1965 who was ultimately found to have neurosensory deafness without a family history and with no other neurological or physical abnormalities. The mother had had ruptured membranes for a period prior to delivery but no evidence of sepsis. Because of a low grade fever and some listlessness, a lumbar puncture was done on the infant during the first few days of life. This yielded spinal fluid containing a moderate number of cells, primarily polymorphonuclear, with a slightly elevated protein and normal glucose. Diplococci pneumococci was finally cultured from this fluid. Initially the child received a one or two day course of Streptomycin and later Kanamycin. These antibiotics were stopped, and penicillin alone used, when the final culture was reported. At no time was the child severely ill. In any age group this type of meningitis is extremely serious. This is particularly true in the newborn and the very old. If the individual survives, there is usually a residual neurological deficit.

Because of its unique location at the "Air Crossroads of the World", Anchorage often has epidemics at different periods than other parts of the country. In checking the Epidemiology statistics of the Alaska Department of Health, our sleuthing pediatrician found 1965 to be a time of high rubella incidence in this area. A HI rubella titer was obtained. This was positive 1:80. Such a level usually results from an active rubella infection and not from passive immunization (this patient had not been immunized). It only persists if the patient has had an active infection. Such epidemics still somewhat resemble an "Act of God".

Rubella can notoriously cause isolated neurosensory deafness. Therefore, all of the other questions of medical judgement, such as the use of prophylactic antibiotics in infants of women with prolonged rupture of the membranes, "high risk — special observation", the otitic toxicity of Streptomycin and Kanamycin etc., became academic. One local pediatrician had common sense, superimposed on seventeen long years of practical experience. He had kept current by time snatched from his very busy schedule to visit libraries and medical meetings, and he prevailed over all the "experts". A large number of lawyers, judges, and lay people may have learned something more of the terrible waste of time, money, and talent caused by malpractice suits arising primarily from greed. Hopefully they also got some insight into the excellent caliber of Alaska Medicine.

Sincerely yours,

Helen S. Whaley, M.D.

Well done, John! — Ed.

RE: CONTROLLED SUBSTANCES ACT OF 1970

Dear Sir,

The Controlled Substances Act of 1970 went into effect on May 1, 1971. Following are some of the changes and requirements of the law. There have been many changes in the law already and probably quite a few more to come.

REGISTRATION

Any physician who wishes to prescribe drugs controlled by this act must register with the Bureau of Narcotics and Dangerous Drugs (BNDD). If you have not yet applied, write to:

Dave S. Wood
Bureau of Narcotics & Dangerous Drugs
Room 306, Loussac Sogn Bldg.
439 D Street
Anchorage, Alaska, 99501

In the letter give the place of practice, the number of your old tax stamp (IRS number) or if you didn't have an IRS number, ask for the proper applications. These letters and applications will be forwarded by the local office to the regional office and processed there.

The BNDD has allowed a grace period of 90 days ending July 29, 1971 for all physicians to obtain their registration number. During this period, the following statement must be placed on all prescriptions written for controlled drugs: "Federal registration applied for on (date)." This policy does not relieve any potential registrant from the responsibility to immediately apply for registration if he or she has not already done so. No activity (with the exception above) with controlled substances will be permitted without the use of a valid BNDD number.

There are exemptions from the registration outlined in Part 301.25 of the Federal Register. (a) The requirement of registration is waived for any official of the U. S. Army, Navy, Marine Corps, Air Force, Coast Guard, or Public Health Service who is authorized to prescribe, dispense, or administer, but not to procure or purchase, controlled substances in the course of his official duties. Such officials shall follow procedures set forth in Part 306 of this chapter regarding prescriptions, but shall use the service identification number of the issuing official in lieu of the registration number required on prescription forms. (b) if any official exempted by this section also engages as a private individual in any activity or group of activities for which registration is required, such official shall obtain a registration for such private activities."

In order to change your registration adding or subtracting schedules of controlled substances, a new application similar to the original registration must be made except that there is no fee involved. The registration of an individual ceases when such person dies, ceases legal existence, discontinues professional practice, or changes his name or address. In any of the above events, the Director of BNDD should be notified. Upon change of address or name, a new Certificate of Registration should be applied for and fee paid in advance of the change (per Federal Register). No registration or authority conferred can be assigned or otherwise transferred except upon such conditions as the Director specifies and then only after his written consent.

Registrations are also required for each separate location maintained by a registrant.

SCHEDULES OF DRUGS

There are now 5 schedules of drugs. These take the place of the old narcotic and non-narcotic classifications (Classes A, B, X, and DACA Drugs).

Schedule I — These are substances with high potential for abuse that have no currently acceptable medical use. In this group are opiates and opiate derivatives such as heroin, hallucinogens such as LSD, Peyote, mescaline, marihuana, psilocyn, tetrahydrocannabinol, DMT, etc. Interestingly, the Native American Church has received an exemption from the law to use peyote in their religious rites only. Any person manufacturing or supplying them peyote must register and keep records.

Schedule II — These are all the former Class A narcotics (Codeine, Morphine, Demerol, Methadone, Percodan, etc.) and injectable methamphetamines. Any injectable containing any amount of methamphetamine in it comes under this schedule. No refills are allowed for these drugs.

Schedule III — This schedule contains all the old Class B narcotics (a narcotic plus another active ingredient such as aspirin, Tylenol, etc. Examples are Empirin Nos. 1, 2, 3, 4, Tylenol c Codeine.). Also in this schedule are all the amphetamine containing drugs (Dexedrine, Dexamyl, Desoxyn (oral forms), Preludin, Ritalin, all barbiturates except phenobarbital, barbitol, and methohexital (Brevital). This includes amobarbital, secobarbital, Tuinal. Other depressants listed in this class are Doriden, Noludar, etc.

In states where Paregoric can be sold in quantities over the counter, it is treated as a Schedule V but when prescribed, it is Schedule III.

Schedule IV — These are drugs that have a lesser degree of abuse than the Schedule III drugs. These specifically are Barbitol, Chloral Betaine (Beta-Chlor), Chloral Hydrate, Ethychlorvynol (Placidyl), Ethinamate (Valmid), Methohexital (Brevital), Meprobamate, Methyphenobarbital, Paraldehyde, Petrichloral, and Phenobarbital. Any drug not listed above that falls in the general class of these drugs will be in Schedule III.

The major difference between Schedule III and IV lies in the penalties for violation.

Drugs in Schedule III and IV can be written with refills. The Act permits 5 refills or that the prescription is valid for 6 months whichever comes first in the refill authorization. This includes the old Class B narcotics.

There are exceptions for some drugs containing the above preparations. They are in combination with other active ingredients which make it hard for abuse. Some examples are Pamine PB Elixir (not Drops) and Half-Strength tablets, Butabel preparations, Phenaphen Plus, Mediatric, Bellergal, Cardilate-P, Dilantin with Phenobarbital, Edrisal, Robinul-Ph, etc. These exemptions are allowed on the amount of controlled drug in each dosage unit. The exemptions are listed in the Federal Register.

Hearings are being held June 30, 1971 to determine whether to move all methamphetamine oral preparations into Schedule II. This would exclude any refilling or oral prescriptions for these preparations.

Schedule V — This schedule consists mainly of the former "Class X" or exempt products, both prescription and over-the-counter such as Cosanyl, Phenegan VC with Codeine, Lomotil Cheracol, etc. Paregoric is the exception, as stated before, in that it is also controlled in Schedule III. The amount of narcotic per unit dose cannot exceed the amount listed in the Federal Register.

PRESCRIPTIONS

Prescriptions for Scheduled drugs must include the following information.

1. Name and address of the patient.
2. Date prescribed.
3. Medication, strength, amount, and directions.
4. Name, address, and BNDD number of the practitioner.

Oral prescriptions can be given for drugs in Schedule III, IV, and V. Prescriptions for Schedule II drugs must be in writing except in an emergency situation.

An "emergency situation" is one in which the prescriber determines:

1. That immediate administration of the controlled substance is necessary for the proper treatment of the intended ultimate user; and
2. That no appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under Schedule II of the Act, and
3. That it is not reasonably possible for the prescribing practitioner to provide a written prescription to be presented to the person dispensing the substance, prior to the dispensing.

In such an emergency situation, the pharmacist may dispense a Schedule II controlled substance on an oral prescription provided that:

1. If the prescribing physician is not known to the pharmacist, he must make a reasonable effort to determine the legitimacy of the authorization, such as a check in the phone book to verify the prescriber's phone number, a call-back; etc.:
2. The oral prescription must immediately be reduced to writing, containing all the information normally required in a written prescription except for the physician's signature by the pharmacist.
3. The quantity must be limited to the amount required to treat the patient during the emergency period only.

Thereafter, within 72 hours, the prescriber must furnish the pharmacy with a written prescription marked "Authorization for Emergency Dispensing," and the date of the oral order which must be attached to the written notation previously made by the pharmacist and filed in the Schedule II prescription file. The burden of supplying the signed prescription is on the prescriber, and the prescriber, not the dispenser, will be penalized if this requirement is not satisfied. However, the pharmacy must inform BNDD if the prescriber fails to deliver the signed authorization as required. The pharmacy's failure to do so voids the original oral authorization, and makes the emergency dispensing unlawful. (The above information on oral prescriptions was taken from a release sent to me by the Legal Division of the American Pharmaceutical Association located in Washington, D. C.)

DRUGS FOR OFFICE USE

Drugs in Schedule II can no longer be obtained through a pharmacy with the Federal Order form for office use. Order forms are obtainable through the BNDD. These orders must go directly to the company or wholesaler. When the order is made, 2 copies are sent to the company and 1 copy is retained (third copy). When the drugs are received, the amount received and date received must be entered on the retained copy. This copy and the invoice must be kept and be readily retrievable.

A prescription for Schedule III, IV, and V drugs can be written for in reasonable amounts for office use only. A prescription cannot be written for office supply that is to be later dispensed to the patient to take home.

According to the Federal Register, physicians do not have to keep records of controlled substances that are prescribed or administered in the lawful course of his

professional practice (administered in the office). The only time that records are required is when the controlled substance is charged for either separately or together with other professional services (e.g., When he substitutes his services for those of a pharmacist).

A pharmacist may also supply not more than one ounce of a 20% aqueous or oleaginous solution of any controlled drug to a registered practitioner for administration, provided a written record of the transaction is made indicating the date of the transaction, the name, form, and quantity of the drug supplied, the name, address and registration number of the practitioner to whom the drug was delivered. If the controlled drug supplied is listed in Schedule I or II, an official order form must be used as the written record of transaction. (This was taken from a letter received from the National Association of Retail Druggists Legal Department.)

DISPENSING OF NARCOTIC DRUGS FOR MAINTENANCE PURPOSES

306.07 — The administering or dispensing directly (but not prescribing) of narcotic drugs listed in any schedule to a narcotic drug dependent person for the purpose of continuing his dependence upon such drugs in the course of conducting an authorized clinical investigation in the development of a narcotic addict rehabilitation program shall be deemed to be within the meaning of the term "in the course of his professional practice or research" provided that approval is obtained prior to the initiation of such a program by submission of a Notice of Claimed Investigational Exemption for a New Drug to the Food and Drug Administration which will be reviewed concurrently by the FDA for scientific merit and by the BNDD for drug control requirements, and that the clinical investigation thereafter accords with such approval, as required in 130.44 of this title.

(The above was taken directly from the Federal Register)

INVENTORY REQUIREMENTS

Any controlled drug should be inventoried and the record of the inventory has to be kept for two years. The date of the inventory and whether it was at the beginning or close of the day is needed. A new inventory has to be taken every two years.

Sincerely yours,
Myrle A. Myers, R.Ph.
Secretary-Treasurer
Alaska Pharmaceutical Association

MEDICINE AND MEDICAL HISTORY

Dear Sirs,

How will historians and future citizens of the north assess the role individual physicians and medicine have played in the development of Alaska?

As social scientists become more interested in examining the social and cultural aspects of our history and drift away from interpreting the past solely in political, military or economic terms, they will need collections of original source materials in the arts, literature, health and social sciences to re-evaluate the past in more humanistic terms.

In order to describe and evaluate the practice of medicine in the present as well as in the past, scholars will need access to unpublished records. These source materials will aid in describing the impact physicians and their

practice of medicine have had on peoples and communities living in arctic and sub-arctic climates.

Only the availability of documents will enable researchers to deal with the full spectrum of medical services which developed in Alaska. It will make it possible to trace the development of a vigorous state medical association, designed to promote better and more effective medical care for Alaskans.

An appreciation of the role medicine and individual doctors have played is critically important to a fuller understanding of our culture. Decreased infant mortality and an increased life span, the elimination of tuberculosis (as a widespread disease) among the native people as well as the legalization of abortion are among the many aspects of medicine that have had a tremendous physical, psychological and social implications for our culture.

One of the most effective ways of gaining an insight into the role, functions and important contributions of any group of professionals in the State is to study the records of the associations and societies they have formed to facilitate and promote their work. Obviously, the Alaska State Medical Association is the primary organization to examine in order to gain an understanding of the medical profession in the State today. The records of the Association should give scholars an idea of the problems which faced medical practice in Alaska, as well as a view of the concerns and interests of individual doctors and community medical groups on matters of both professional and legislative concern. Committee reports would illustrate how the Association determined basic policies, while formal minutes of the House of Delegates would document basic policy stands and direction of the Association.

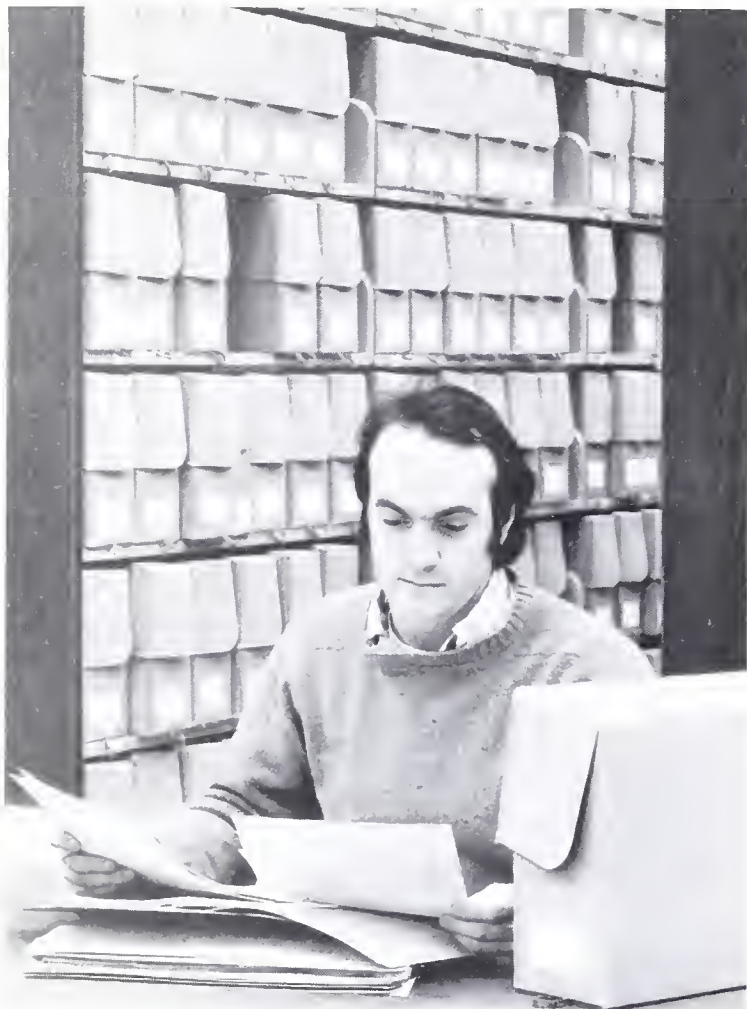
In order to insure that future scholars and researchers will be able to gain an insight into the history of the Association, the House of Delegates of the Association resolved to establish an Archives of its non-current records. At the invitation of the University of Alaska, the collection has been established at the Archives and Manuscript Collections of the University.

Annual reports, minutes, committee reports, important correspondence, publications, and other materials of historical importance will be included. In cases where the original documents should remain with the Executive Secretary, copies of the documents will be placed with the Archives to make the collection as complete as possible.

While the records of the more recent years of the Association are rather comprehensive, those of the years immediately after its establishment in 1945 and the following years are much less complete. We would like to appeal to each of you active in the Association at that time to examine your files for materials on the Association. We would sincerely appreciate it if you would contact the Executive Secretary or the Archivist of the University of Alaska should you have material in your files that would fill in the many gaps in the Association's early history. Through the efforts of each of the older members of the Association it may yet be possible to develop a comprehensive record of the activities of the Association. I am taking the liberty of forwarding directly to you three photographs that illustrate some of the activities in the Archives.

The first one is a photo of a student examining some of the records in the Archives which are housed in acid-free file folders and especially designed archival boxes to insure their preservation for many, many years, since the main emphasis of the Archival Program is to preserve materials for researchers and students who might wish to utilize them for serious scholarly research.

The second photograph is one of our staff members removing an archival box from one of our shelves for the use of a researcher. We try to emphasize that we need to preserve a larger number of historically significant manuscript collections for the use of future researchers.



The third photo pictures one of our students using a tape recorder to listen to oral interviews. The oral interview technique might be particularly appropriate to gather some of the early recollections of physicians involved in founding the State Medical Association.

Sincerely yours,
Paul McCarthy
University Archivist and
Curator of Manuscripts
The Library
University of Alaska
College, Alaska 99701



“RH IMMUNE GLOBULIN QUESTIONS ANSWERED”

Dear Sir,

Use of Rh Immune Globulin (Rho Gam^R) for the prevention of Rh hemolytic disease in newborns will help to prevent occurrence of a disease leading to deafness, cerebral palsy, and mental retardation.

As a result of concern expressed by Dr. William Ivy, Anchorage Obstetrician, concerning how to provide Rho Gam^R to Alaskan mothers delivering in areas where a laboratory is not available, the following question was put to Dr. Arthur J. Salisbury, Director of Preventive Service for the National Foundation:

“What methods are available and what are the indications for administering Rho-Gam^R to mothers when laboratory facilities are not available for cross-matching the mother's cells within 72 hours after delivery?”

In addition, we asked Dr. Salisbury:

“What are the indications for using Rho Gam^R for women following spontaneous or induced abortion?”

Dr. Salisbury forwarded these questions to Dr. Louis K. Diamond, Professor of Pediatrics at the University of California at San Francisco and Director of the Blood Grouping Laboratory of Boston, who replied as follows:

"Your questions regarding the use of anti-Rh gamma globulin were referred to me by Dr. Salisbury of the National Foundation-March of Dimes. We, both here and at my Blood Grouping Laboratory in Boston, have had considerable experience with these problems.

"All unsensitized Rh negative women having an abortion should be given anti-Rh gamma globulin, unless the father is a proven Rh negative individual. Although the gross statistics, as quoted by Freda, suggest the chances of sensitization are not as great as after delivery of an Rh positive baby at or near term, the final figures from many Obstetric Centers are not yet in and the risk of sensitization is too great to be ignored, while the gamma globulin injection is harmless.

"Cross-matching is so simple, any laboratory anywhere should be able to do it. This test of the gamma globulin vs. the woman's cells merely ensures that her cells cannot be destroyed by a possible rare antibody which might occur in the gamma globulin. The chances for this happening are infinitesimal and even if it did, the amount of gamma globulin injected is hardly enough to produce serious hemolysis in an adult. Therefore, I'd be willing to go ahead even without a cross-match.

"Finally, in many communities, the layman has heard and read so much about the protective value of the anti-Rh gamma globulin that any obstetrician who neglects to use it could very well find himself accused of negligence, even in rural areas. In my several talks around here and in the East, this has already been brought to my attention.

"I trust this gives you the information you wish."

Sincerely yours,
Donald K. Freedman, M.D., M.P.H.
Director
Division of Public Health

THE ACCA

Dear Sir,

The Alaska Treatment Center for Crippled Children and Adults (formerly the Alaska Crippled Children and Adults Treatment Center — ACCA) has been providing services for Alaska's handicapped citizens for many years. The Treatment Center functions within the medical model, with a Medical Director and Medical Board in addition to an Executive Director.

Services are offered through five departments within the Treatment Center. Pre-School classes in the Special Education Department include the Diagnostic Nursery, Multi-handicapped Nursery, Language Development, Speech Motivation, and Deaf and Hard of Hearing. Learning disabilities tutoring also is offered to individuals requiring this service. The Department of Psychological Services includes intellectual, emotional and achievement appraisals. The Speech and Hearing Department determines the nature of speech disturbances and provides the type of training that will improve or correct the condition. The audiology Department provides hearing testing service to all ages, to assess not only the hearing level of the individual involved but also to serve as a diagnostic aid in determining the site of lesion in a patient with a hearing deficit. Therapeutic modalities used in the Physical Therapy Department are all part of a program to help the patient achieve his maximum

performance in self-care, work and social activities. In this comprehensive rehabilitation program at the Alaska Treatment Center, it was recognized that one very important factor in the program was missing. As a result of these many longstanding services, the need for family counseling was clearly demonstrated.

In August of 1969, the Center expanded its overall treatment program to include psychiatric social work services. As with all of the services offered at the Alaska Treatment Center, medical consultation in the specialty of psychiatry is used for assistance in case planning. Through utilization of the diagnostic process and treatment skills, based on certain psychoanalytic principles, the focus of the new service lies in providing professional casework therapy involving child, adult and family counseling with the primary emphasis being on a family approach to problem-solving. Although social work has traditionally emphasized material supplies and environmental conditions, inter-personal processes have become crucially important. With the development of dynamic psychiatry, internal feelings and concerns expressed via social relations are becoming dominant and significant measurements for mental health.

It has long been recognized that mental health of individuals is related to the family, and when one family member is experiencing difficulties this affects other family members and their behavior. At Alaska Treatment Center it has been noted that in families where one member is involved in a therapy program for some specific physical problem — e.g., a speech defect, a language or learning disability, orthopedic or neurologic involvements — there are often related emotional difficulties within the individual and/or family system. The psychiatric social work program is designed to work closely with all other therapy departments and classroom programs at the Alaska Treatment Center to provide an encompassing treatment program for individuals suffering from various physical and emotional handicaps.

Psychosocial diagnosing necessitates an evaluation of the patient's past and present social and intra-psychic functioning to arrive at immediate as well as long term treatment goals. According to Ackerman, "it is imperative to trace clearly the dynamic relations between specific trends of family conflict and the intra-psychic conflicts within an individual member," for this relation is basic to the question of individual and family stability.

The primary patient, whether he be child or adult, is in Ackerman's words, "often an emissary in disguise of an emotionally warped family group." The family as a group develops a major pattern. Certain pairs of relationships exist which may be the basis for family diagnosis. The psychiatric social work program at the Alaska Treatment Center arrives at family diagnosis by assessing the particular problem of stress that the family is undergoing, the capacities and disturbances of the individual family members, the nature of family interaction, goals and goal states (assuming stages of development). This concerns evaluation of family roles, communication, interaction, complementarity of role interaction, normative patterns and transaction between family members. The pattern of family interaction determines whether the first treatment focus should be on the marital relationship, on an individual's personality problem, or on the member's extra-familial roles — or a combination of all three. Within this process and with the assistance of regular psychiatric consultations, the Department determines intricacies of focus and psychotherapy.

These patients and their families need to be helped to work through many hidden feelings and difficulties they have in relation to their emotional and physical handicaps, many of which involve considerable underlying anxieties. In treatment for "dis-ease", it is hoped that physicians, with

their realization of the need for comprehensive services in helping people deal with a myriad of problems, will avail themselves of these services which are a part of the total rehabilitation program.

Sincerely yours,
Bill W. Mollerstrom, M.S.W.
Psychiatric Social Worker
Alaska Treatment Center

ON QUACKERY

Dear Sir,

The Quackery Committee, during its first year of function, has been actively involved in investigating health fraud. A review of our State Licensure Regulations reveals them to be hopelessly inadequate to protect our citizens against all forms of quackery. Within the past year, inquiries have been made to the State Department of Licensure from naturopaths, homeopaths, and herbalists. Even in the case of the recognized profession of chiropody (podiatry), all that is required is a business license to hang out a shingle and go to work. At the writing of this report, there is a current ad in our local Anchorage newspaper encompassing two columns six inches in length by an unqualified "therapeutic hypnotist" practicing from a room in the local hotel. Although repeated efforts have been made to prevent this individual from fleecing our populace, the statutes do not allow the Attorney General to take action.

It was felt that with the powerful chiropractic lobby in our State Legislature, it would be fruitless to try to remove these cultists from practice. One deterrent to their increased activity, however, would be the limitation of their use of ionizing radiation. Consequently, in April of this year, Senators Josephson and Thomas introduced Senate Bill 230. Essentially, this bill would limit the use of ionizing radiation on human beings to doctors of medicine, osteopathy, and dentistry. Hearings were begun in the Senate Health, Welfare and Education Committee on the 21st of April on this radiation control bill. Local Juneau chiropractor, Donald Hammond, D.C., testified against the bill, the approach being that most chiropractors receive course materials in radiology which are equivalent to or superior to medical school training. He stated that without the use of x-rays, chiropractors would be unable to make

diagnosis and the possibility of the mistreatment of chiropractic patients would be increased. He further stated that all but a few Alaskan chiropractors have x-ray equipment. Dr. Hammond further conceded that he and other chiropractors complained that the Godfrey Clinic in Anchorage had been using radiology in excess, giving their patients "full spinal" x-rays as a standard practice. The Quackery Chairman discussed this matter with Dr. Hammond on the 22nd of April while in Juneau, at which time he requested that the Medical Society take no action on this bill, stating that the Chiropractic Board planned to control such excessive use by administrative regulations. Dr. Freedman, Public Health Director for the State of Alaska, testified at the Committee's request. A luncheon interview with Senators Thomas and Josephson of Anchorage, and Terry Miller of Fairbanks was extremely enlightening, and turned into an educational session for the three senators. Factual information was presented, documented by printed material. At the conclusion of this interview, it was agreed that although this type of legislation was definitely needed, it would not perform the complete purpose of eliminating quacks and all forms of health fraud in the State of Alaska. They have agreed to submit legislation, dealing with this matter, in the next Legislative session.

It is extremely important that every physician practicing in the State of Alaska educate his patients concerning the detrimental practices of chiropractors and other quacks. In order to do this, each must be educated himself. Consequently, in the coming months, each of you will receive a copy of a pocketbook "At Your Own Risk — The Case Against Chiropractic" by R. L. Smith. Read it. Each legislator lists someone as his family physician. If you are that physician, take time out to educate him. Most of them are ignorant of the true facts of why medicine opposes chiropractic. Many of you have specific instances of actual harm done by many of these cultists. Please document them and send them to the committee chairman or to the State Medical Association office to assist us in strengthening our case. Prior to the convening of the next legislature, a meeting is planned in both Fairbanks and Anchorage between representatives of Medical Society and the local legislators to properly inform them of the Medical Society's stand. Your help is earnestly solicited. Alaska can be the first in the nation to rid itself of health fraud.

Sincerely yours,
Herbert H. James, M.D.
Chairman, Quackery Committee



For the first President's Page of my term there is herewith printed the remarks I made in Juneau as a sort of inaugural address. Though some of you heard them and others have seen excerpts in the press, I feel it appropriate that you have the opportunity to see what was really said. While I am quite in earnest about the marihuana bit and hope the Legislative Committee does indeed draft appropriate legislation to legalizing its use, I feel that the other points are more pertinent for our overall concern.

At the AMA convention in Atlantic City (may it rest in peace) I had the opportunity, along with many city and state police and Secret Service agents, to hear President Nixon speak on various issues. I was happy to note that in many areas he fully agreed with me and called upon us all to become involved. Therefore, let us press on toward an exciting year.

PRESIDENT'S PAGE

By J. Ray Langdon, M.D.

(Direct quotation of Public Address given to ASMA House of Delegates, June 1971.)



"In the 12 years that have passed since Juneau was last the site of the Alaska State Medical Association convention (the first as Alaska State Medical Association rather than Alaska Territorial Medical Association) this country has passed into — probably not through — a massive convulsion which is rivaled only by the Civil War since the original Revolution. Ingredients have included racism, civil rights, the Indochina War, drugs of all sorts, womens liberation, gay liberation and the youth protest. From where I sit the medical profession as a whole — American Medical Association and the various specialty organizations as well as the medical schools — have chosen to sit this out, electing to be non-involved spectators.

I recognize that Alaska has had its special concerns with statehood, population growth, oil finds, etc., but Alaskans happen to be people much like other Americans and its physicians are no more heroic than elsewhere. We have complained about United States Public Health Service and Bureau of Indian Affairs, but have paid little

attention to the natives whose complaints we really should be voicing. We have watched the drug and youth problems grow and have watched while the police advocate hardline enforcement and noxious vermin, such as the professor of sociology on the faculty of the University of Alaska, advocate reinstituting the death penalty — for problems which are basically medical and which we as physicians should be taking responsibility.

It is incongruous and ludicrous that a group of men — and a few women — who are generally recognized as the best-endowed and best educated as a group — can sit by and watch a whole sick society writhe in agony and blithely imply that it is not our baby. We are very refined in our scientific achievements in atomic medicine and hyperbaric chambers and consoles of laboratory tests, but we have forgotten we live in a society where needles are often unsterile and illegal, where 20-30 people can be murdered with no one even missing them, where doctors are often looked upon as oppressors rather than healers.

It appears that we are at the moment in a period of less violence, that our young people are less militant and that we are coming into the sunshine. Let me point out that the eye of the hurricane is also fairly calm but the other side of the storm may produce even more forceful winds. Perhaps we can yet interject our capabilities into solving our pressing social, economic and health problems before it is too late — at least we should try.

We should:

1. Actively seek to pass adequate medical disciplinary legislation — *and then use it*. As you may know we are not alone in lack of self-discipline — the bar association is also bad and it is practically unheard of for a policeman to be disciplined for anything but being late or out of uniform.

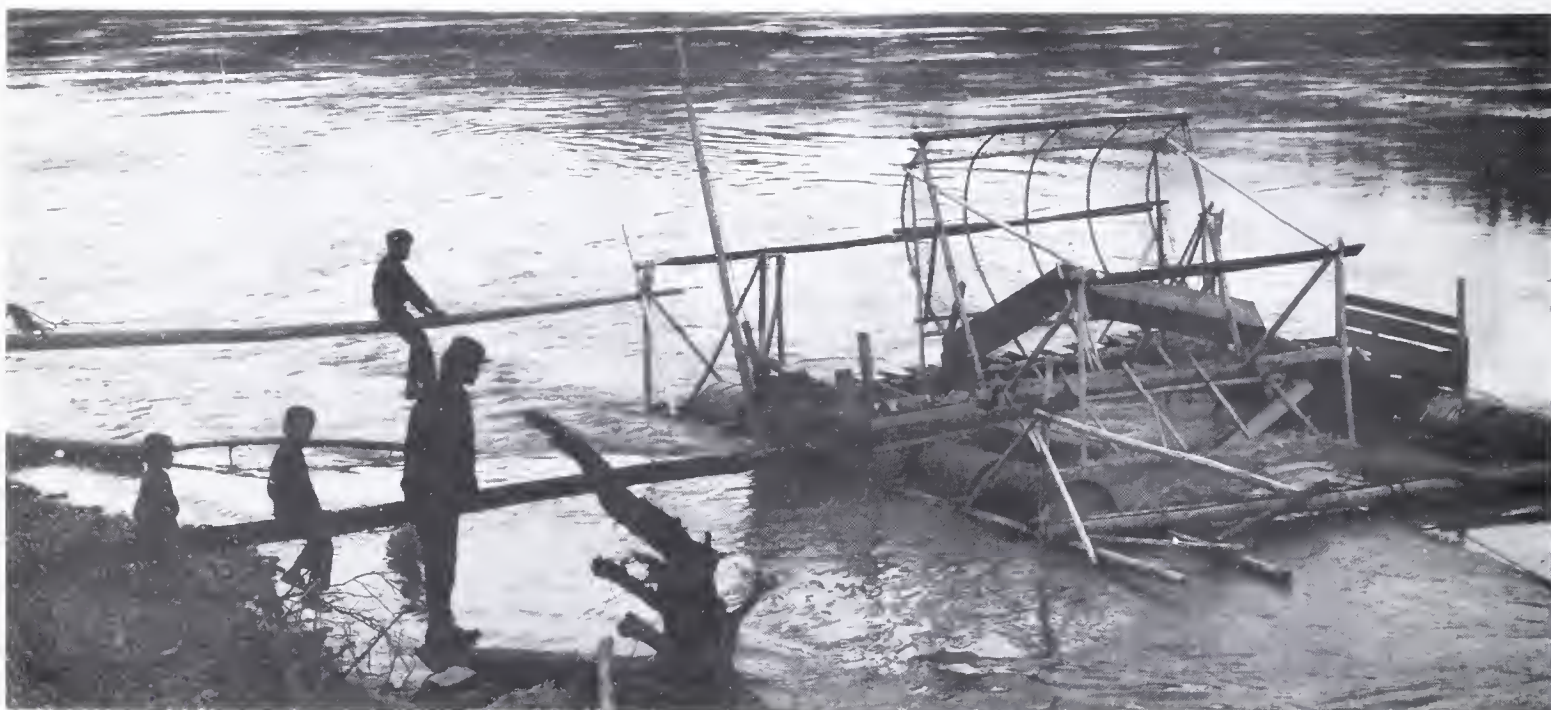
2. Look closely at our public agencies involved with health care — not only whether they are paying us adequately but also if they are doing a good or even marginal job. Alaska Psychiatric Institute, McLaughlin Youth Center, The Welfare, the multiple non-public health aspects of the Division of Public Health moulder and fester in obscurity when it is the medical profession which has the know how and the obligation to investigate, assist when possible, and complain vociferously when necessary. We have often complained in the past, but frequently about minor or trivial issues, and have seldom attacked the basic incompetence or even malevolence of the public systems.
3. Pay serious attention to the increasing non-education being passed out by our educational system. We are apt now to be concerned if there is an adequate football or orchestra program — maybe we should wonder if reading is being taught, if native or black students are given some chance, if drug and sex education programs are being taught under watered down John Birch rules or by medically sound principles.
4. Look beyond malpractice suits into whether or not any semblance of justice is being dispensed by our courts and correctional systems. It would appear that most of our drug, sex, mental health and juvenile laws warrant the concern of the profession and certainly the physical

and mental health of all in “correctional” institutions should be our direct concern.

5. Take a second, third or further look at military and VA medicine and practices. We, most of us, have been there — were we satisfied then and should we be now? What about the 80,000 plus heroin addicts our military establishment has produced in South East Asia, some of whom have been and will be returning to Alaska?

This is a brief, superficial overview of what I think we have not been doing enough of and what we have done is often backward or too late. I propose that the Alaska State Medical Association has a right and responsibility to be concerned and to voice opinions about many social problems which it has been reluctant to do. I feel that it was right in supporting abortion law reform and that it should now encourage the legalization of marijuana, the abolition of many of the nefarious sex laws still on the books, the reform of our present court and penal systems, and the upgrading of various institutions and laws such as Alaska Psychiatric Institute, community mental health centers, etc.

In the brief year in which I am your president I hope for your support in continuing the programs we have started and for starting more. I assume that my views on these matters are somewhat known to those who voted for me so that I have a mandate to proceed as rapidly as I can. As I pointed out earlier, the hour is late and we have very little time. Let us work for the night is coming.”



A HEALTHY ARGUMENT

By **Ted Stevens**, *United States Senator*

Speech given to the Alaska State Medical Association, Juneau, Alaska, June 10, 1971.



Someone has suggested that the times we live in should be marked, "Subject to change without notice." At first, the suggestion seems not only witty, but apt. Examined more closely, it reveals an interesting contradiction, for the essence of change is that it is noticed.

Such a change was the giant stride into the unknown which American social policy took six years ago, when Congress enacted two large new programs for publicly supported medical treatment — Medicare and Medicaid.

It's been said that when innovation takes place, there is an intimate linkage, or fusion, of two or more elements that have not been previously joined in just this fashion, so that the result is a qualitatively distinct whole. If we may use a biological analogy, an innovation is like a genetic cross or hybrid; it is totally different from either of its parents, but it resembles both of them in some respects.

A New Creation

I submit that when government and medicine were thusly fused, something quite different was born into American society — something which we have yet to fully measure and weigh and comprehend.

This new creation resembles one element, the medical profession, in that healing arts are brought

to the sick; and resembles the other element, government, in that it has grown far bigger, far faster, than anyone anticipated.

The country's total medical outlays, private and public, rose from \$25.9 billion in 1960 to \$67.2 billion last year. That's roughly 7 percent of the gross national product. In the same period of federal government's share of these outlays rose from 13 percent to 27 percent, in large part because of the government's new role in helping pay the hospital and medical bills of the aged and poor.

Figures for Medicare and Medicaid tell the story dramatically: they made their appearance in President Johnson's budget for the fiscal year ended in June 1967, at \$4.3 billion; the current year's estimate is \$11.5 billion and next year's is \$12.6 billion plus another \$4 to \$5 billion for the new legislation now proposed by President Nixon.

Eight new health-care bills have already been submitted to Congress, and others will probably be introduced as debate warmed up this summer. As you may know, I am a co-sponsor of both the A.M.A. and the Administration bills — two pieces of legislation that are compatible in basic concept in that they do not seek to tamper with the traditional doctor-patient relationship.

Areas of Agreement

The important point to note is that everyone of these bills says that more Americans should get more medical services of better quality. All of them, for instance, agree that the distribution of personnel and services must be changed from the present allocations. All of the bills speak both to the economic differences and the need to iron out some of the economic disparities in availability of services. They also take into account geographic disparities.

All agree that the organization of the staff that provides health services and the facilities have to be changed, if there is to be a change in access to health care by individual people within the United States. And all agree that costs should be commensurate with services, although none really defines how this is accomplished.

All agree that the risk of illness and the risk of the costs involved in the maintenance of health should be spread more evenly, and to a greater extent, over the entire population of the United

States. And all agree that controls of both quality, quantity and cost are essential, although there is considerable disagreement about how best these controls may be instituted and carried out.

All the bills propose some kind of minimum standard of benefits package, to be defined and provided for specified populations. All emphasize ambulatory care, rather than an emphasis on inpatient institutionalized care, although both are provided for in all of these bills.

All agree that there must be requirements in law and in regulations which will assure not only quality, but continued assessment of quality. All agree there must be some kind of continuing education available to people who are providing health services and that there is a federal stake in the preparation of health workers. And all agree that there cannot be a sudden jump from where we are now to Utopia. Therefore, all have a phasing-in of population groups and an expansion of benefits over a period of time, ranging from two to four years.

Whither From Here

Great areas of disagreement do exist, however, and that is why I am co-sponsoring the A.M.A. and Administration proposals. They preserve what I feel must be preserved, and meet the needs which must be met. In short, they make sense.

The claims advanced on behalf of other bills strike me as too extravagant. We've heard these claims before. They always remind me of Deems Taylor's remarks to a music student who had scored a thunderous passage for massed French horns: "That's very impressive, son," he said, "but you'd better save something for the second coming of Christ."

Yet these legislative attempts to seek immediately all the goals of Utopia are increasing each year. More bills, calling for more public services, are introduced side by side with demands for tax cuts.

We cannot ignore possible Utopias, for they exist in the same way that north and south exist. If we are not familiar with the classical statements concerning each, we at least know them as they spring to life each day in our own minds.

Utopias are the needles that point in the direction some of our people would like our society to go. The republican society of the Founding Fathers, with its promise of "life, liberty, and the pursuit of happiness," was a Utopia — something to be achieved.

The clash between ideologies in Congress today is not between things as they are, but between things as we would like them to be. It is a clash, in short, of the Utopias — of where we go from here.

Nearly every Utopia I have heard of was devised as a response to criticism of the *existing* order of things. In America, Utopias have taken easily identifiable forms.

In one, we sought to build a great society in which there were no poor and in which everyone who is able to work could find employment.

The depression of the 1930's spawned another type of Utopia. In a time when jobs were very hard to find, the expression of Utopia was not a place where everyone could find work, but "The Big Rock Candy Mountain." It was the dream of a workless society.

As we try to grope our way toward the end of the century we find the Utopian compass pointing in opposite directions.

Much has been made, for instance, of the ability or competency of government — whether federal, state or local — to solve all problems, to create any Utopia that can be devised by man. Too much has been made of the capacity of government to insure that everyone is happy in other words, too many people believe all problems can be solved politically.

Government in our free society simply cannot be solely responsible for all good or evil — we can only help create the conditions which will foster good and discourage evil.

What Are Necessities?

There is another question that must be asked. "What is the basic necessity for the services sought to be provided by government?"

We are no longer content to rest when we have achieved the level of living which *had* to satisfy our forebears. Our necessities are as binding on us, with the expectations our people have now, as were their necessities on them.

As a people, as a Nation, we have accepted the idea that proper health care is a *right*. The basic dispute in Congress is how to deliver the health care we all agree is necessary. The body politic today considers the "body healthy" a necessity, and seeks its guarantee.

Whether that guarantee will arise within the framework of an open, free-choice relationship between doctor and patient, or evolve along lines of government intervention in that relationship will be determined this summer by the Congress.

You and your colleagues throughout the Nation can have a great impact on the outcome of the deliberations of Congress this year. I urge you to be positive — recognize, as the A.M.A. has, that Congress *will* act this year — and to explain your point of view not only to Congress but to each segment of your own community. It's the same old problem — *communication*. If we are to avoid a "healthy argument" over delivery of health care, *all* lines of communication must be open and must be fully utilized.

Every American has a right to

demand
receive
purchase

excellent
good
fair
poor

ambulatory
hospital

health care.

By Arndt von Hippel, M.D.

Would you like your son to become a doctor? In the past one might have considered quite reasonable such responses as “Oh, yes!”, “Sure”, “Of course”, or “Why not?” Before answering this question at present, however, one had best reflect a longish moment.

Times are changing. Our U. S. Senior Senator Ted Stevens points this out graphically elsewhere in this issue. As physicians, we are suddenly in an interesting position. We are about to have our federal government guarantee the delivery of our services, by a means and at a price to be determined by government career physicians and legislators.

At present, the only right to professional services guaranteed by U. S. law is the right of the accused to services of an attorney. Common experience suggests that this has often guaranteed only shoddy or mediocre care to the accused unless he is lucky, infamous, or rich. It appears that the court-appointed attorney often responds to such routine and unprofitable demands upon his time with disinterest or indifference. One might have reasonably anticipated that when the public set its own price for a service that was only potentially available, a reduction in the quantity and quality of that service would follow.

We are currently entering a phase of progressively more unrealistic demands upon limited medical services and facilities. Why are our services and facilities limited? Many people blame physicians and medical leaders, yet current limitations appear to be financial rather than subsequent to restrictive practices of physicians. As far as I am concerned, it just isn't my fault and I refuse to share any mass burden of guilt.

A definite change in the pattern of health care delivery appears inevitable. It might be well, therefore, to briefly consider the three most common modalities for the delivery of health care by physicians: (I) Career Government Service, (II) Private Practice, (III) Kaiser Permanente et al (K. P.). Each of these “programs” has similarities and differences. I will dwell here only on obvious differences in productivity and rewards.

Every purposeful activity has some reward. That is obvious. No matter where or how a

physician works, he has the emotional and financial rewards that follow from the appropriate utilization of his training and abilities. There is quite a difference, however, in the reward systems of the three groups.

Career Government Medicine: (VA, USPHS, etc.)

Most long established federal medical programs place a premium on obvious measures of medical care delivered, especially the highly visible in-hospital segment of sick persons. Many federal career physicians point with pride to the alleged low cost per hospitalized patient in federal institutions. In addition, as salaried physicians, they radiate a faint aura of superiority over their money-grubbing private practice brethren. Somehow, ever since we started medical school, we have been taught that a salary is inherently superior to fee for service; that a person who serves for a fee does so only for that reason, while a person who serves while on a salary does so mostly from innate goodness.

Certain truths should be obvious but bear repeating. Federal career physicians are currently well paid, very well paid. They are probably paid better, on the average, than their money-grubbing cousins out in practice. The main reason that they are better paid is the fact that, although they are often proud not to be a member of the “Union”, they have benefited from wages set to compete with “Union” wages. Furthermore, they are allowed to purchase low cost food (P.X. privileges), they frequently have tax free salaries (25% cost of living allowance, etc.), they support no overhead, they get an excellent retirement income (contributed largely by the taxpayer), they take fully paid world-wide trips to meetings (courtesy of the taxpayer), paid vacations, paid sick leave, etc. In brief, they are clearly among the upper class of the almost untold legions of federal employees, and their claims to either poverty or excessive virtue on financial grounds are tenuous.

How about the low cost of federal patient care? One can hardly exaggerate the thousands of sources and great variations in fund expenditures possible within the federal health system. It would

be less than surprising if a federal actuary someday proved, using federal health expenditure figures at federal facilities, that the government made a profit on every patient hospitalized.

As for efficiency, it is an almost universal experience that a physician leaving a federal health care facility to enter private practice will markedly increase his patient care work load. In part this occurs because he, who is most directly involved, is now in charge of organizing his own time. He is also the direct beneficiary of any increase in his own efficiency. Finally, he generally just plain works harder, because he wants to, or because he has to, to make ends meet.

Private medicine profits by patient turnover and efficiency; federal medical programs have most usually benefited in proportion to the gross number of patient hospital days. In the past there has been little federal budgetary distinction between one patient in the hospital for 90 days and 90 patients in the hospital for one day. Obviously, great productivity under such a reward system would be contraindicated, since a chronic patient is usually a very inexpensive patient, compared to the acute troublesome medical care patient.

The rewards of good work in such a federal hospital situation are (1) promotion, (2) no budget cut in hard times, (3) increased budget allowance, more hospital construction, and larger staff in good times: And above all, never fire anyone, just kick them upstairs, higher into the taxpayers pocket, so they will have a larger retirement income at an earlier age. This will be paid for, in part, by those tax-poor who cannot afford to retire from private practice. That is the Golden Rule of Bureaucracy.

Conclusion

On the average, career government medical doctors do not work as hard, make at least as much money, and retire at a younger age. So what are you worrying about?

K. P.

So what about that Great White Hope — Kaiser Permanente et al? Sounds great! Preventive Medicine! A proud sound ever since public health programs have been killing mosquitoes. Thousands of lives saved at a mere pittance.

Ah, the ideal bureaucratic solution. The doctor should coinsure the patient! Make the doctor benefit by keeping the patient healthy and out of the hospital. Well . . . at least out of the

hospital. That is the place where health care costs really get racked up!

Healthy patients love Kaiser Permanente. The yearly examination, the \$5.00 — \$10.00 automated blood tests, the EKG's and x-rays, the whole bit! So what happens if you get sick on old K.P.? You feel terrible. Say you broke five or six ribs and your clavicle in a motorcycle accident. You feel faint. You beg to stay in the hospital, at least overnight, in case something might happen.

"No! It isn't necessary for you to come in to the hospital." (the doctor, your coinsuror, says.)

Say your daughter gets in trouble and needs an abortion.

"Sorry!" (says the doctor, your coinsuror) "It's against policy. It's not covered!"

Possibly you think you need coronary artery surgery or kidney transplant surgery or open heart surgery (one of those fancy modern \$10,000 to \$20,000 operations that drives the cost of medical care up out of sight.) No fear now of being subjected to unnecessary surgery for profit!

"Well," says the doctor, your coinsuror, "we have a contract with Stanford. They do any of that surgery that *we* feel is necessary, and old K. P. pays for it. However, luckily, your type of angina responds best to nice inexpensive nitroglycerine, so you won't need any of that expensive and dangerous surgical stuff."

"We see no reason for any heart surgery on you at this time, Mr. Joe Blow."

"But of course, Senator Snort, we would be delighted to pay for your care at Stanford, and your wife, and your kids . . . certainly all seven kids."

Every American has a right to help his politicians decide on the level and quality of medical care that will be available to all Americans for the next generation. Undoubtedly there is great room for improvement in the present mix of private, prepaid plan, and government medical care. It seems unlikely however, that the more radical of proposed alterations will do more than decrease efficiency, raise costs, and substitute "pull" for the money incentive.

The topnotch quality of health care currently available to much of our population is based on individual initiative and effort, individually rewarded. There is no reason to assume that this will endure under a dissimilar system. Basically, you get what you pay for, not what you demand. Services cannot be seized.

IS THE AMERICAN SYSTEM WORKING?

By Frederick J. Hillman, M. D.

The Politics of Technology. By Frank von Hippel and Joel Primack, 167pp. Stanford Workshops on Social and Political Issues, Stanford University, Ecology Center Press, 1360 Howard Street, San Francisco, California 94103.

Americans are rightfully proud of their system of government but we sometimes forget that it was designed for a small, homogeneous, agrarian population. Since the writing the Constitution and the Bill of Rights, the country has changed in every conceivable way, and one can say, as Heraclitus said of the ever-changing river, that it is not the same nation as The Thirteen Colonies. How pertinent to the United States of 1971 are the documents which were hammered out in Philadelphia in 1787 and the institutions which have grown out of them, by statute and by tradition, to become the government of the nation?

The catalogue of national and international problems is all too familiar — the twin spectors of overpopulation and the bomb; the war in Vietnam, and all the problems that it has brought into focus, such as the ever increasing power of administration, and the willing away of citizens' liberties one by one, the deterioration of urban life, the pollution of the biosphere coupled with the exhaustion of our resources, the integration of minorities, the distribution of wealth, the interrelated economic problems of control of business cycles, inflation, and employment. Finally, and not least, is the question of who is going to pay for health services, and who decides who may treat whom, where, and how.

A scientifically oriented society might be expected to have institutions which would use the problem-solving technique familiar to all scientists. Since the United States is democratically as well as scientifically oriented, one might expect that each tentative and hypothetical solution for a social problem would be widely debated, and that the issue finally would be decided according to the merits of the alternatives by vote of the peoples' representatives in Congress. The resulting plan would be administered by the executive branch and reviewed by the judiciary to keep it in line with the fundamental plan of the nation, the Constitution. Jefferson may have had something like this in mind. In practice how well are the institutions of our present government functioning in problem-solving? Three books have recently come to my notice which seem to answer "not very well."

The Politics of Technology by Dr. Frank von Hippel (who is the brother of our editor and

Decision. By Richard Harris, 220 pp. E. P. Dutton & Co., Inc. 201 Park Avenue South, New York, N. Y. 10003.
The Satisficers. By Arthur Levin M. D., 187 pp. The McCall Publishing Company, 230 Park Avenue, New York, N.Y. 10017.

Professor of Physics at the Argonne National Laboratory) and his colleague Dr. Joel Primack, is an indictment of the decision-making process in the Executive Branch of our government. In a Stanford workshop on political and social issues they studied seven recent federal technological decisions

- the design and location of commercial nuclear reactors,
- the environmental and economic impact of the supersonic transport (SST),
- the danger of earthquakes being triggered by underground testing of nuclear weapons in the Aleutians,
- the adequacy of federal pesticide regulations,
- the effects of herbicides,
- the safety of cyclamates,
- the adequacy of the design of the Safeguard (ABM) system.

What they learned in studying these examples shocked them. Many technical decisions are ostensibly based on the advice of a Presidential Science Advisory Committee (PSAC). When technical advisors expressed concern about dangers inherent in policies being pursued by the Executive, however, their reports have generally been suppressed or misrepresented. At the same time the eminence of the advisors was used to buttress the case for the objectivity and non-political nature of the decision. Spokesmen for the Executive have emphasized the quality of their expert advisors, but when the facts and the advice do not support current administration policy, the Executive has denigrated them. In effect, the advisors have been used to give the appearance of legitimacy to what are basically political decisions. Moreover, the best experts have been preempted by the Executive. Congress has had few experts of its own, the public none. Dissenting experts have been muzzled by rules forbidding disclosure of confidential information. Each of the seven cases should have been a widely debated political issue based on widely disseminated technical information. Each became an arbitrary decision of the President to suit his own political purposes, with attempts to exclude the public and Congress from the decision-making process.

The history of the Amchitka bomb tests illustrates the actualities of the present system. A PSAC panel was formed to study the possible

effects of the test, including the dangers of earthquakes and tsunamis being triggered by the tests. A panel was convened in November 1968 under Kenneth Pitzer, a former director of research for the Atomic Energy Commission. It found that tests in Nevada had triggered small earthquakes, and that elsewhere small earthquakes often had triggered larger ones. Earthquakes in the Aleutians had resulted in destructive tsunamis as far away as Hawaii and Japan. The panel concluded that it was "seriously concerned with the problem of earthquakes resulting from large yield nuclear tests" and called for release of information, relevant to an informed public debate.

The Pitzer report was suppressed, despite chairman Pitzer's repeatedly urging that it be released. Meanwhile the AEC issued reassuring statements that "a number of this country's most eminent seismologists have concluded that the probability that a large nuclear event might trigger an earthquake of the same magnitude as the seismic signal from the explosion itself is very small." Chairman Pitzer was prohibited from releasing the report or from speaking about the subject except as an individual. Despite the adverse report, the AEC conducted the one megaton Milrow test as scheduled.

A test five times as potent is planned for this autumn. The fears about its safety are now five times as grave but the AEC appears five times as determined, and the publicity five times as blandly reassuring. The 1968 report stated "the Panel believes that the public should not be asked to accept risks resulting from purely internal governmental decisions if, without endangering national security, the information can be made public and decisions can be reached after public discussion" In no recent Executive technological decision has the public been kept informed of technical aspects or been asked to participate in the decision.

In "Decision" political journalist Richard Harris shows how the Senate operates when faced by a challenging problem. In 1969 the President nominated Judge Haynsworth to be associate justice of the Supreme Court, but his nominee was found to have sat in judgement on cases in which he had a financial interest and was rejected by the Senate. Six months later, in order to fulfill his pledge to place a southern conservative on the Supreme Court and, many thought, to fulfill his "Southern Strategy" which might enhance his chances for re-election, Nixon appointed Judge Harrold Carswell, an appellate judge from Florida, whom Attorney General Mitchell called "too good to be true." Evidence quickly came to light that Carswell was mediocre if not incompetent, and had been rated far down on a list of candidates prepared by the Justice Department. As one of his

supporters, Senator Hruska, said "there are a lot of mediocre judges and people and lawyers. They are entitled to a little representation aren't they . . .?"

Moreover, Carswell was an avowed segregationist. Moderate Black leaders held that his appointment would be devastating to the tenuous control which they held over the Negro population, and would set back by a generation the integration of Negroes into the mainstream of American life. Facing the challenge, the senate was in no mood to fight so soon after the bitter battle over Haynsworth, and the nomination seemed assured. The spark that kindled enough opposition eventually to defeat Carswell's nomination came chiefly from a coalition of civil rights lawyers and the young aides to Senators Bayh, Kennedy, and Tydings. The contest was bitterly close, up to the final count which depended on the votes of four uncommitted senators. "Decision" has all the suspense of a first rate detective story. The anti-Carswell forces were aided by several lucky breaks and by the incredibly sloppy performance of the White House Staff, which Harris shows as not only cynical and arrogant, but inept, uninformed, and naive.

"Decision" is an education in the complex political machinations that make the Senate function. One is impressed by how sensitized a Senator becomes to political pressure, how seldom an issue is decided solely on its merits, and at the same time how a vital issue can be fought far from the public eye. (Senator Gravel received only 75 letters on Carswell, and yet he was a key figure at one stage of the struggle.) The question arises — should there not be a better system for rejecting nominees submitted by a cynical and political president than one which depends on the conscience and zeal of Senators' aides?

The "Satisficers", by Arthur Levin M.D. is a kind of horror tale — an expose of the failings of The Surgeons General Office of the Public Health Service. Dr. Levin spent two years in the SGO (1966-68) and became completely disillusioned with it. The title is a corruption of the words "satisfy" and "suffice" which he applies to bureaucrats who are doing just enough to hold their jobs, while together as an agency they are utterly failing in their assigned task of defining and solving social problems. The book describes how decisions were muddled or postponed, how planners, spending millions of dollars, neither sought nor received any advice about problems, (e.g. future national research needs); how planners seldom actually did any planning; how experts were called in for advice at great expense and the advice then ignored; how HEW made no attempt to evaluate the effectiveness of its programs or of local projects within these programs; how the statisticians gathered data but never asked the

questions that their data might have answered; and how the efforts of temporary policy makers (e.g. Congress) were frustrated by career program administrators. Dr. Levin describes his lessons in how the government reacts to — but not necessarily acts upon — social problems; how momentum is lost and nothing happens, always at great expense; and how the voice of the ordinary citizen grows fainter and fainter in the confusion of advisory bodies and committees that have sprung up throughout the government. He found “satisficers” everywhere, experienced the remarkable inertia of a large bureaucracy, and came to the conclusion that “we have lost the ability to influence our government.” Finally, he quotes John Gardner (after Mr. Gardner left HEW) “there are some things that are gravely wrong with our society as a problem solving mechanism.” The “Satisficers” is an account of some of these things.

How pertinent are these three books to the concerns of the physicians? Why should a review of them take up space in a medical journal? Because each gives an insight into how the government machinery is working — the machinery that is going to grind on future physicians, willy nilly. Health care has become a faddish popular concern, and has become a politically useful vehicle for politicians. This is not to deny either the real problems in the field of medical care or the valid idealism of legislators and administrators. The social and economic aspects of medicine are changing even more rapidly than the technical. Physicians are going to find themselves increasingly under the influence of governmental agencies, legislators, and impersonal forces, not the least of which will be inflation. *Decision* makes us suspect that legislators will decide a medical issue, not on its merits, but according to the sum of political pressures on them, and the potential for political gain. If Dr. Levin is accurate, we can predict that

the ever-burgeoning bureaucracy will have ever increasing inertia, be ever less responsive, and have an ever increasing proportion of “Satisficers.” Drs. von Hippel and Primack warn us of the increasing remoteness of the decision-making process from the public and from Congress. They show that Executive decisions likewise tend to disregard the merits of an issue, to suit the convenience and ends of the administration in power. The Executive is currently pushing health maintenance organizations (HMO’S). Is one being cynical to suspect that even Nixon does not think that HMO is the “best” solution to the complex problems of health care, but rather that the HMO plan is politically expedient?

Physicians are only a small and politically negligible segment of the voting public. No administration or administrator is going to pay much attention to what an individual physician says or even to what his organization, the AMA, says. Can physicians expect the Executive who supported Carswell and the Amchitka tests to deal with matters of medical care forthrightly and objectively? Can the “Satisficers” of HEW be expected to administer a national health plan with intelligence flexibility, and compassion? Will either deal kindly with dissent? Probably few legislators or administrators understand the realities of clinical medicine, or much care how their plans affect physicians or patients, or really think that physicians have any worthwhile opinions on these matters. Physicians can perhaps best use their energies by staying informed, by trying to educate legislators and potential legislators, and by supporting changes in the administrative machinery that will make the bureaucracy less cynical, less arbitrary, less rigid, less impersonal, less incompetent, and more in tune with physicians’ ideals and ideas.



ST. MARY'S CLINIC

By Milo H. Fritz, M.D.

John Spahn and I were up at four in preparation for a five thirty takeoff from Anchorage. The takeoff was delayed until eight thirty because of ground fog at St. Mary's where we arrived at noon in the F-27 with a stop at Bethel. The Bethel area was a Joseph's coat of autumn color in the center of which, like a slightly tarnished buckle, lay the little city.

Helicopters buzzed in and out of the newly made airstrip, airplanes from Cessna 150s up to 727 jets were taxiing around the runways, landing or taking off. The river was churned up with taxiing floatplanes, power barges, and small boats with outboards astern in constant activity. Along the roads, plumes of dust were raised by speeding taxis, trucks, graders, and other road machinery. Beside the roads, housing projects were going full blast in order to beat the imminent arrival of winter. All this activity would have provided an atmosphere of diligence in a city ten times Bethel's size. But in Bethel it was overpowering.

The airstrip at St. Mary's is now long and well developed, and the F-27, once considered a large and ponderous plane, seems small indeed on the vast new runway.

We were greeted by our old friend Brother Benesh of the Mission and he took our expensive excess baggage and our freight to the Mission seven miles away.

Here, too, the autumn colors were more brilliantly orange and red with a softer background of orange and gold provided by the grasses which had been killed by the early frost.

At the Mission we were moved into our usual guest quarters that the Sisters had provided with a jar of candy which neither one of us needed, a little packet of towels, wash cloth, toothbrush, and toothpaste. Our glasses were never long empty of fruit juice, pop, milk or tea, and the frequently proffered cups of coffee were made even more tempting with piles of cookies from the Mission kitchen across from the guest room.

Father James Laudwein greeted us with his new clinic nurse, Miss Candy Peabody, R.N., of Boston. Candy had screened all the people in the village and all the youngsters at the school who wished to have their eyes examined. She provided us with a list of names with the visual acuities alongside.

Armed with this important and time-saving document, we quickly decided to begin with those with poorest vision and end up with those who had nearly normal or normal vision. We worked in the long classroom right off the busiest of halls with

the door open so the youngsters could see what their classmates were enduring. From one classroom the endless "K,T,S,D,K,T,S,D," of the typing teacher could be heard. From another classroom a discussion of problems in the Near East was audible. Occasionally, far down the hall, laughter, applause, or a muffled voice of some student or teacher showed school was in session.

The ear-splitting bell punctuated these pleasant sounds from time to time to denote the end or the beginning of a class, resulting in my lowering the world's record for the indoor sitting high jump until a day or two had passed and I became used to it once more.

As the youngsters had their homatropine and paredrine drops put in up the hallway near the small infirmary, they would come into the examining classroom. All had complete eye examinations and at least an examination of their ear drums and throats besides.

Often, classmates of the patients would stop by and stand quietly in the doorway or come in the room to observe the proceedings, thus perhaps educating those who had no need for eye and ear, nose and throat care, and dissipating any feelings of anxiety, any fear or mystery, about these simple procedures.

Of one hundred thirty eight patients examined we found forty eight with chronic ear disease ranging from chronic mastoiditis to simple dry perforations of one or both ear drums. This discovery, nothing new and reiterated many times since 1940, underlines once more the need for the removal of tonsils and adenoids when the first indications for this operation appears instead of waiting until diseases such as are recorded of the ENT statistics become so tragically prevalent.

The change from hyperopia as it is seen commonly in the Eskimos in their forties or older to myopia in the younger generation is something which, if understood, might alter the knowledge of myopia throughout the world. The principal problem from the ophthalmologist's point of view is proper opticianry and the prompt provision of sturdy, attractive spectacle frames at reasonable cost.

John Spahn's contribution to these clinics is indispensable. He shows one or two people on each clinic, and in each village we visit, how to adjust glasses, select frames, make minor repairs, and measure a patient's face, taking into account the distance between their pupils and the length between the spectacle frames and the top of the ear in order to supply proper temples. The one

hundred and four eyeglasses that were prescribed reached the students within two weeks of the day that we left, a great improvement over the three to six months delay that has always been the case when contract spectacles were provided, plus the monumental fact that the glasses fit.

In this clinic, also, as at Emmonak earlier this year, the patients purchased their own spectacles, a small but significant step away from socialism. Those youngsters who could not afford the purchase of spectacles were provided them by the general village council of St. Mary's and through certain funds available through Father Laudwein.

The more deeply pigmented the eyes, the more resistant they are to cycloplegia. The use of cyclogyl in these brown-eyed people is poor ophthalmology. The young people often describe their eyes (irises) as "black", and they are entirely refractory to anything less than toxic doses of this drug. Nevertheless, somehow, cyclogyl got onto the drug supply table of the United States Public Health Service here in Alaska. The result is that physicians who have only a very superficial knowledge of refraction tend to overcorrect nearsighted people. We found this, not only at St. Mary's, but also in Emmonak. I found one patient who was wearing a -3.00 sphere before his eyes when his actual need was +1.25! The use of homatropine and paredrine results in almost complete cycloplegia when two drops of each are used and the interval between the drops is two to three minutes. The patient is ready for examination in an hour.

Patients with chronically discharging or intermittently discharging ears from either recurrent mastoiditis and otitis media, or otitis media alone, when admitted to the Alaska Native Health Service Medical Center Hospital in Anchorage, or even to one of the satellite hospitals, tend to have the discharge cease without any medication and with nothing more than proper food, proper rest, abundant water for bathing and washing, and a good, well-balanced diet. When these are supplemented by proper medication, ears tend to dry up in an astonishing way without surgery. Some of us know from experience, however, up to thirty years in my own case, that when the youngsters catch cold the discharge starts again.

Those more recently introduced to the ear problems of Alaska, though excellently trained, tend to ignore the experience of those of us who have been here so long, and attempt to do fancy operations for the restoration of ear drums to complete normality. While the youngsters remain in the hospital in Anchorage for several weeks without any difficulty and with apparently intact ear drums, a false sense of accomplishment is generated. For the most of the cases will break

down again when they are restored to the village life with all its restrictions. With the first cold or even before, the ear drums perforate and the discharge appears once more.

Beginning in 1957, the Lempert endaural radical mastoidectomy with a primary Rambo closure and the use of a temporalis muscle flap to fill the combined middle ear-mastoid cavity was introduced. With that, the period of hospitalization dropped from many months to one or two weeks with ninety five to ninety eight percent permanent drying up of a chronic mastoid infection. Occasionally, a cholesteatoma or a cyst would occur in these completely closed up mastoid and middle ear cavities, requiring, in the hands of Dr. Mahlon J. Shoff or myself, the opening of the area with removal of the cholesteatoma or retention cyst, a relatively minor procedure. Thus, the ear was restored to the condition it was after the first operation, and the patient could swim, dive, and carry on all the usual activities of youth.

One example of how complicated surgery is the wrong solution under bush conditions interested me. Ten years ago I did a radical mastoidectomy with a Rambo closure of the external canal on a boy who was then six years of age. About six months ago, he began to have pain and swelling behind the ear and was taken to the Anchorage Native Health Center to have this investigated. A young surgeon, instead of simply removing the offending cholesteatoma or whatever had appeared in the wound, "restored" the middle ear and after a period of time sent the boy back to school here at St. Mary's.

When he came in the clinic he told the common story that is heard when the patient does not stay in Anchorage or elsewhere where an otologist is available to take care of such complications. He had the usual piece of cotton in his ear, and when I examined it there was a mass of granulomatous tissue with a profuse, foul discharge that excoriated the external ear and the more cephalad areas of the skin on his neck. In other words, attempting to restore the middle ear was a poor decision. This youngster asked if I could not operate on him and do the operation I did years ago so that his ear would be dry and not trouble him as it is now doing and had done up until his operation ten years ago.

Do not interpret this as meaning that I do not feel that normal or nearly normal ears should not be striven for by the otologic surgeon. Far from it, but operating on somebody that can be followed at regular intervals by an otologist in a city is one thing and sending a youngster back to the relatively primitive areas within a few weeks after such surgery is unfortunate, in my own experience in this field.

Well, eventually the chores were done, glasses prescribed, medication prescriptions written, conferences with the nurse, and teaching session in opticianry and the manufacture of hearing aid buttons all concluded, and we eagerly anticipated the trip up the Andreaski River to fish. Early on Sunday morning, with the ground shrouded in fog, the temperature below freezing, and the thwarts and gunwhales of Brother Benesh's skiff, the Grayling, covered with a thin layer of ice, we packed our gear aboard, cranked up the johnson-evinrude (a generic term in Alaska for any outboard engine), and started up the river. As the fog lifted and the sun bored through the gray blanket, the exquisite colors of autumn appeared once more, made even more brilliant by the absolutely pure, clean air, the gorgeous sky, and the golden light of the morning sun. There was enough water in the river so that we were able to go without grounding one time. We even negotiated Narrow Squeak Gap into the upper waters of the Andreaski, so clear that we could see the fish scurrying away from the disturbance created by our propeller. We were huddled in blankets and winter parkas because the air was very cold, and even our slow progress made this bite into our aging bones.

Eight or ten miles from the Mission we stopped at a place in which I had landed my old floatplane several years ago. We were able to catch a couple of Arctic char, a few greyling, an an indignant pike. The pike's pique caused him to nearly amputate my right index finger before he passed on to his reward. Further up the river, at a place indistinguishable from any other place to John and me, Brother Benesh, after a few minutes, called us down from where we were struggling more or less ineffectually to get a few fish. In the hole he chose the fish were bent on self-destruction. They would chase the lure right into the shallow water and on several occasions each of us had a fish on our line at the same time. We soon had enough fish to fill our quota, did the necessary post mortem surgery on the banks of the stream, and took off for home, full of that quiet peace that only another fisherman can understand after such a fabulous day.

We had lunch on a gravel bar and the stew and sandwiches and hot coffee didn't last very long. We

made the trip back to the Mission in time for supper, and in the evening we saw a movie in the priests' residence although John and Brother Benesh and I had a tough time staying awake after all that exercise and fresh air.

Father Laudwein has instituted several important changes in the Mission. The most important, I feel, is a common mess hall for the entire staff. The teaching sisters, the volunteer teachers that come from all over the world, but principally from the United States, and the few Native men and women on the staff, visitors, and the priests, all eat in a common mess and serve themselves buffet style. It is possible in this way for a stranger to sit with the different groups and learn much more about what each one does in the Mission life. It is a busy place and on previous visits there were many people whose activities I wondered about, but because of the segregated eating arrangements I never was able to increase my sphere of knowledge and they, I am sure, didn't know much more about what John Spahn and I were doing than we knew about their activities.

The social highlight was our invitation to have dinner with the Billy Beans family who still live in one of the old cabins though pretty soon they will be moving into a newer one in the village of St. Mary's. The Billy Beans are the first, and so far the only, Native family that has ever invited John and me into their homes without having been dragooned into it by some well-meaning schoolteacher, missionary, or other white person. We feel there that we are asked because they like us and not because they feel it is their duty.

Having visited the village now for over ten years, we have seen many of the youngsters grow from undernourished waifs, clothed in rags, into upstanding outstanding and extraordinarily attractive young students. Some of them are now in college and one or two of them are at this moment graduating with practical nurse degrees from hospitals in Washington or Oregon. There is great satisfaction in having contributed to the intellectual and physical development of these young people and in having been accepted as a part of the Mission staff, sort of externs if you will, of St. Mary's on the Andreaski.

NON SURGICAL REMOVAL OF RETAINED COMMON DUCT STONES

By **Maurice J. Coyle, M.D.**

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In the past few years, Radiology has undergone many changes, but the addition of the TV image intensifier has added tremendously to the diagnostic and therapeutic capability of the radiologist. He can now direct catheters into small selected vessels, aid surgeons in removal of foreign bodies and placement of cardiac pacemakers, and as most recently reported, remove retained common duct stones.^{3, 4, 5, 7}

Recently we were able to save one of our patients a second laparotomy by expelling, under direct vision, a retained stone from his common bile duct. DePalatis recently removed a stone from the common duct with a ureteral stone basket.² Because the procedure is apparently easy, safe, and simple for the patient and physician, surgeons and radiologists should be familiar with it.

CASE REPORT

A 73 year old native male was admitted to the ANMC with a one week history of malaise, nausea, vomiting, and epigastric pain. The patient was jaundiced and his laboratory values were compatible with an obstructed common duct. However, within 3 weeks his bilirubin had returned to normal; an IV Cholangiogram revealed at least one stone in a dilated common duct. The cystic duct was patent, and no stones were demonstrated in the gall bladder. On the 25th hospital day, he underwent cholecystectomy and exploration of the common duct. An operative cholangiogram prior to duct exploration demonstrated multiple filling defects, and numerous irregular multifaceted stones ranging in size from 0.2 to 1.5 cm in greatest dimension were removed. A No. 7 Bakes dilator passed readily into the duodenum. On a T-tube study prior to closing the abdomen, two small lucencies were demonstrated, but were thought to be due to air bubbles as no stones could be palpated. A postoperative T-tube cholangiogram revealed a single 0.5 x 1.0 cm stone in the common bile duct. A repeat examination confirmed the presence of the residual calculus. Four weeks later the stone was again demonstrated.

On the following day, under sterile conditions, the common bile duct was partially filled with Renografin to outline the stone. An attempt was made to thread a ureteral stone basket through the T-tube. However, the acute angle at the T could not be negotiated, so the T-tube was removed. A No. 16 Fr. coude-tipped rubber catheter (with the tip cut off) was easily threaded into the common bile duct through the tract of the T-tube. The coude catheter passed easily into the duodenum; then it was pulled back into the distal common bile duct, and the ureteral stone basket threaded through the catheter. By this time, the stone had moved into the distal duct below the tip of the catheter, and it was felt the duct might be damaged if the stone basket opened. Therefore, it was withdrawn. 10 cc of 1% Xylocaine were injected rapidly through the catheter. Upon re-examination, the stone could not be found in the distal duct. The coude catheter was easily manipulated into both right and left hepatic ducts, and there was no evidence of a stone in the biliary tree. Repeat studies through the coude catheter were done in the following 2 days and confirmed removal of the stone. The catheter was removed, and the patient discharged from the hospital.

DISCUSSION

Injection of ether and chloroform through the T-tube was the most successful early method advocated for removal of retained common duct stones.^{1, 6} However, the method has not been universally accepted, and the hazards outweigh the advantages. Warm sterile saline is the only solution recommended for flushing the common duct.⁸ The newer technique of stone manipulation under direct vision may be a procedure which will obviate re-exploration of the common duct for retained calculi.

The technique we used is that first reported by Lamis et al.⁴ The only modification was the injection of the Xylocaine, which relaxed the duodenum, and probably the sphincter of Oddi,

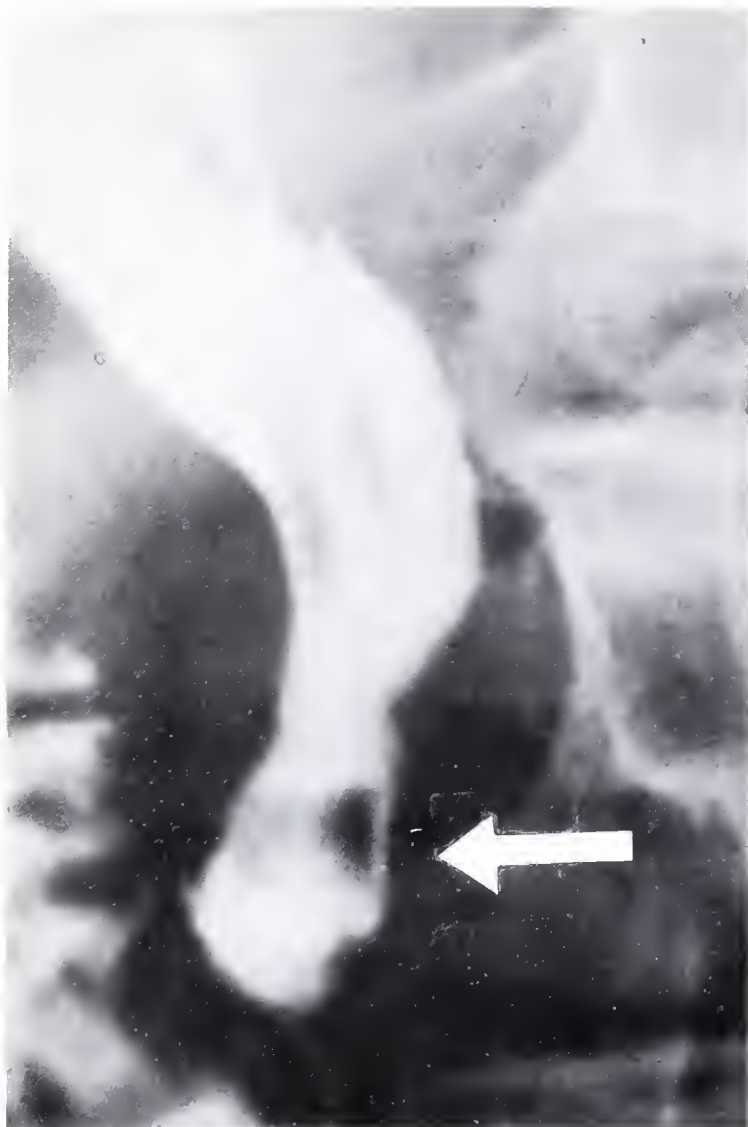


Figure 1

T-tube in common bile duct with stone in the distal duct (arrow).



Figure 2

Coude catheter in common bile duct after expulsion of the stone.

allowing the stone to pass into the duodenum. Obviously, it would be more definitive to remove a stone with a stone basket. However, there is a greater chance of damaging the duct, sphincter, and sinus tract than if a soft rubber catheter is used to expel or remove the stone. Also it is doubtful if one needs to use the directional guide technique described by Mahorner⁷ because it is so simple to pass a coude catheter into the biliary system after the T-tube has been removed. If stones are in the intra-hepatic ducts, one could use the modified Fogarty catheter technique described by Fennessy et al.³

It is difficult to say which is the best procedure as there have been only 6 reported cases in the literature. With improvement in operative cholangiograms, no one will have to accumulate a large series, but everyone should be aware that patients with retained common duct calculi may not need surgery for removal of the stones.

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COMPLICATION OF AURAL FOREIGN BODY

By **K.C. Stewart, M.D.**

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The Alaska Native has a high incidence of chronic suppurative otitis media.¹ Only recently have draining ears been considered a stigma by the Native. Some patients place foreign bodies in their ear canals to occlude drainage. This paper reports an unusual sequela of occlusive foreign body in the ear canal.

A thirteen year old Native male presented at the Alaska Native Medical Center with a long standing history of intermittent ear drainage. At the time of admission the patient was febrile, and edema occluded the right ear canal. Active purulent drainage was present. An inflamed, fluctuant, and tender three by three centimeter mass was noted anterior and inferior to the ear canal. There were enlarged and tender right cervical lymph nodes. Mastoid films showed the right mastoid to be sclerotic, with indistinct cell walls.

Acute mastoiditis was diagnosed. The patient was taken to surgery the day of his admission. A simple mastoidectomy was performed, using a postauricular approach. The antrum showed evidence of inflammation, but the involvement was not sufficiently severe to explain the abscess. Dissection to the mastoid tip failed to reveal a connection with the abscess.

The external auditory canal was explored by extending the incision through the posterior canal wall. A wad of cotton, adjacent to the annulus, was occluding the ear canal. It was saturated with

purulent exudate, and surrounded with granulation tissue. Purulent discharge welled from the middle ear space when the cotton was removed. Exudate continued to drain from a point in the anterior external canal wall just lateral to the annulus. There was a connection between the abscess and the canal through the temporomandibular joint. A dependent penrose drain was placed through the abscess cavity to the middle ear.

Examination of the cleared middle ear showed a chronic perforation with cholesteatoma medial to the ossicles. Further surgery was deferred until the acute process had resolved. One month later a modified radical mastoidectomy with type III tympanoplasty was performed. The patient's subsequent course has been uneventful.

Discussion:

Foreign bodies of the ear canal are common, and have ranged from Abacus beads to Zinc white pearls. Complications are unusual. The reported case shows that acute mastoiditis and abscess formation are potential sequelae.

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FOREWORD

Lt. Col. John F. Nelson, D.C. U.S.A. has been a close personal friend and fraternity brother for nearly 20 years. Always a very outstanding student, he is headed for the top in academic medicine. Jo, his very pretty wife, is a practicing hygienist and also graduated Number 1 in her class. John and Jo have one son who seems to be following his fathers forte both academically and in athletics.

John has just taken and passed his American Academy of Oral Pathology exams having already qualified and passed the Oral Diagnosis specialty boards. Research and teaching have been his main areas of activity after formal

training at the University of Idaho, University of Minnesota, and University of Pennsylvania. He has authored and published seven papers dealing primarily with basic research in cancer. Having made the Army his career his present assignment is with the Armed Forces Institute of Pathology, Washington, D.C. John's next assignment is Saigon, South Vietnam where he will command all dental activities in that area.

The Alaska Dental Society is grateful to you, John, for your time and interest in present this article for publication in our journal. — Aubrey Stephens, D.D.S.

THE PROBLEM-RIDDEN TONGUE

By John F. Nelson, B.S., D.D.S.

According to popular opinion the only problem with the human tongue is its tendency to talk too much! Long known to be an indicator of health status, the tongue can often tell us a great deal if we are prepared to "listen" through the medium of careful inspection of this very accessible organ. The purpose of this paper is to deal with some of these other problems.

The tongue may be defined as a movable muscular organ located on the floor of the mouth, subserving the special sense of taste and aiding in mastication, deglutination, and articulation of sound. This multiplicity of function is indicative of its importance as an anatomic entity. The physiologic complexity perhaps accounts for the varied pathology of the tongue. An understanding of these abnormalities is of prime importance to the dentist and to the physician.

Diseases of the tongue may be divided into the following five basic categories:

1. Developmental
2. Physical
3. Systemic
4. Inflammatory
5. Neoplastic

It is beyond the scope of this paper to do more than discuss a few examples as they relate to this classification.

The tongue may be deformed at birth. Often these deformities, which include clefts, fissures (Fig. 1), uneven swellings, abnormal size and shape, and abnormal muscle attachment, are related to a broader disease process or syndrome. Examples of this include the fissured, serrated tongue (lingua plica) seen in the Melkersen—Rosenthal Syndrome and the variably clefted tongue seen in the Orodigitalfacial Dystostosis Syndrome.¹

The thyroid gland develops as a result of an epithelial invagination of the dorsal tongue surface. This tissue migrates caudally during embryogenesis



Fig. 1

The clinical appearance of a fissured tongue.

and finally locates itself in the antero-lateral neck area. Remnants may remain along the migratory path, however, and give rise to a lingual thyroid mass or a thyroglossal tract cyst. The accessory thyroid tissue may become functional, and as has recently been reported, carcinomatous change may occur in the cyst.²

Physical agents such as irradiation or chemical burning may alter the appearance and function of the tongue and its supporting structures. Generally these factors manifest in deformity caused by an excessive connective tissue response. This results in cicatrization and limitation of movement.

Systemic disease often involves the oral cavity and especially the tongue. It has often been stated that the appearance of the dorsal surface of the tongue is a reflection of the physiologic health of the patient. Hypertrophic papillae, as seen in black "hairy" tongue, or absence of papillae as seen in anemia or deficiency states, are examples of this. In advanced pernicious anemia the characteristic "Hunters Glossitis" is seen. It is postulated that the

atrophy of papillae is due to a reduced rate of nucleic acid synthesis with a reduced rate of cell division.³ Since these cells have been shown to be replaced at the rate of approximately once every three days under normal conditions,⁴ an etiologic basis is apparent.

Primary amyloidosis may, and often will, involve the tongue and pharynx in the form of irregular lumps. Secondary amyloidosis, curiously, usually spares these structures.⁵

Central nervous system disease such as amyotrophic lateral sclerosis results in weakness of the tongue and limitation of movement. The condition is often detectable through observation of successive wave-like tremors or fasciculations across the dorsal surface.

Endocrine imbalances may alter the relative size of the tongue. A hypothyroid state in an adult or a child may result in macroglossia. Hyperpituitarism in an adult will usually result in the same thing.

Inflammation may be considered, in its most simple context, as the localized response to an irritant. Under normal conditions it is closely followed by the phenomena of repair. Delayed healing or the continued presence of an irritating factor may, however, elicit an overexuberant response or a chronic granulomatous condition. Minor trauma, possibly aggravated by secondary bacterial involvement may result in the pyogenic granuloma (Fig. 2). Other bacteria such as the tubercle bacillus and fungi such as histoplasma capsulatum cause chronic granulomatous lesions formed in response to their specific pathogenesis.

Of essentially unknown etiology but at least partially inflammatory in nature is the condition known as benign migratory glossitis or geographic tongue (Fig. 3). This intriguing and not uncommon lesion is characterized by denuded areas of filiform papillae. These change their location with some rapidity from week to week accounting for the descriptive names.

A tumor by definition is a swelling. However, by common usage it is thought of as an uncoordinated new growth of tissue with great potential for independent growth. Tumors are benign or malignant and many types of each category may occur in or on the tongue. These include those originating from epithelium, lymphoid, neural, vascular, fibrous, and muscular tissue (Fig. 4) as well as bone and cartilage. Cases have been reported in which tumors consisting of dense, viable, lamellated bone were observed on the dorsal tongue surface close to the circumvallate papillae in the foramen caecum area.⁶

The most common intraoral malignancy is the squamous cell carcinoma and the most common intraoral site is the lateral tongue surface (Fig. 5). Of interest is the hypothesis that several factors,



Fig. 2
The clinical appearance of a pyogenic granuloma.

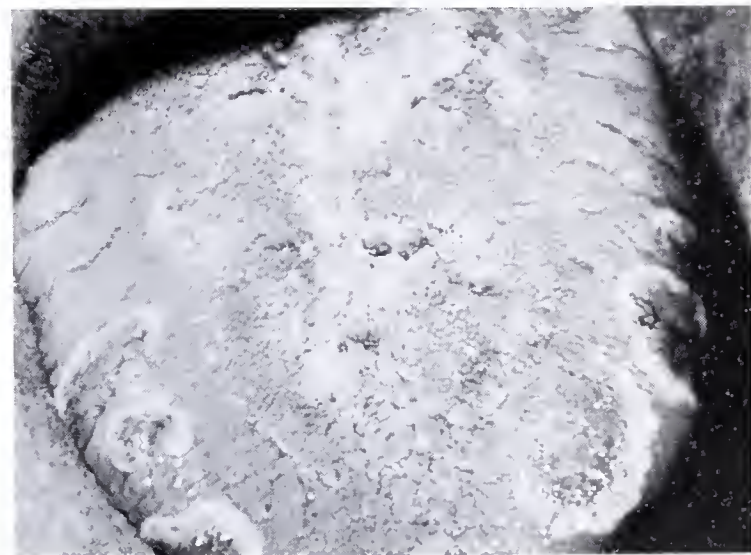


Fig. 3
The clinical appearance of a geographic tongue.

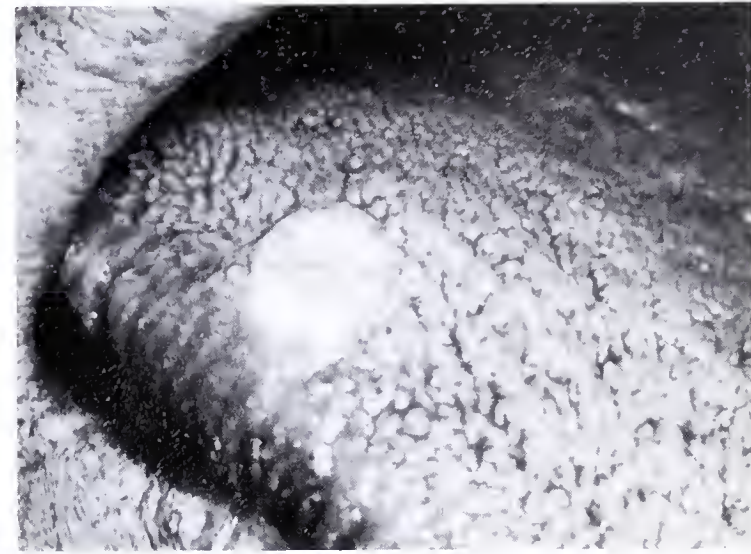


Fig. 4
The clinical appearance of a granular cell myoblastoma.

acting collectively through a pattern of repeated applications on susceptible epithelium such as that of the tongue surface, may stimulate cellular alterations. According to this theory, these "co-carcinogens" eventually lead to irreversible alteration which manifests as carcinoma. Included in these causative factors are alcohol and tobacco consumption, syphilis, cirrhosis, diabetes mellitus, tuberculosis, anemia, and oral trauma.⁷

The dentist all too frequently is concerned only with a patients teeth, and pays little attention to the tooth-supporting structures and the oral and paraoral soft tissues. Examination of these components and especially the tongue, provides the alert diagnostician, whether he be a dentist or physician, with valuable pertinent patient data.

Listen to the tongue!

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Fig. 5
The clinical appearance of a squamous cell carcinoma.

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6. Krolls, S.O., Jacoway, J.R., and Alexander, W.N.; Osseus Choristomas (Osteomas); *Oral Surg., Oral Med., and Oral Path.*; In press.
7. Nelson, J.F. and Ship, I.I.; Intraoral Carcinoma: Predisposing Factors and Their Frequency of Incidence as Related to Age at Onset; *JADA* 82:564-568; Mar. 1971.



AURORA DENTATUS

Dr. Geraldine Morrow's term as president has concluded. She performed an outstanding service to her profession and to Alaskans during her tenure in office. A perfectionist, she carried through with all important society affairs and worked diligently with the members and the public in the interest of good dentistry and good dental health for Alaska. She attended and conducted many meetings, local and national, to the credit of the Society, as in the photograph right.

The Alaska Dental Society is proud and grateful.

Thank you Gerry.



Dr. Carlton H. Williams, left, speaker of the ADA House of Delegates, chats with Dr. Geraldine T. Morrow, president of the Alaska Dental Society, and Dr. Clifford A. Patterson, president of the Idaho State Dental Association at the American Dental Association's 3rd Regional Conference held at Portland in April.

ANNUAL MEETING - HOMER

Highlights:

Dr. Carl A. Laughlin, President-elect of the ADA, is an exemplary leader and champion of his profession and private enterprise. His comments were timely and provided much hope to those of us who despair some of the trends apparent nationally.

Dr. Harold M. Kramer, 11th District trustee as always had done his homework, was informative, congenial and helpful.

Dr. Ralph W. Phillips, probably the greatest authority on dental materials, kept everyone's attention with his superb lectures. They were all too brief.

Dr. William J. Marley, the perfect host who had everything under control but the weather.

*Seafood Fest Beach Party
(Beach attire by Eddie Bauer)*



NOTES ON THE EIGHTH ANNUAL IMMUNIZATION CONFERENCE

By Elizabeth Price, M.D.

Elizabeth Price M.D.

*Chief, Community Health Section
Alaska Department of Health and Welfare*

The United States Department of Health, Education, and Welfare Center for Disease Control held its Eighth Annual Immunization Conference in Kansas City March 2-4, 1971. This provided a forum for presentation of current expert recommendations about immunizations and an assessment of their present status in the United States. This article is a report to the State of Alaska from this meeting.

Diphtheria — There were almost 500 cases of diphtheria last year, nearly twice the number in the preceding year. It is of interest that the immunization level in San Antonio, which had an outbreak of diphtheria, was similar to the urban level elsewhere in the United States. Susceptibility amongst Negroes and Mexicans is ten times as high as amongst Whites. The Chicago Board of Health has distributed diphtheria culture media to hospital emergency rooms to help identify the disease.

Whooping Cough — The incidence of pertussis has dropped dramatically since the vaccine went into general use. In 1970, however, there were three cases of whooping cough in Alaska.

Smallpox — The campaign against smallpox has been highly successful, with a 77% decline in 1970 when compared with 1969. Dr. William H. Foege, Director of the Smallpox Eradication Program, reported that more persons in the United States die from smallpox vaccinations than from the disease. The risk of complications is particularly great with primary vaccinations, and especially amongst children less than one year of age, who run the risk of five fatalities for every 1,000,000 vaccinations administered!

Half of the deaths are considered preventable. If there is any question in a particular case, according to Dr. Foege, the vaccination should not be administered. He urged that vaccination should be concentrated amongst the persons at high risk: travelers can be readily controlled. The world should be free of smallpox in less than five years, Dr. Foege predicted.

Poliomyelitis — Poliomyelitis may again reach epidemic proportions unless immunizations are actively encouraged, according to Dr. John J. Witte, Chief of the Immunization Branch. He cited the decline in the proportion of children aged one

to four who are adequately protected against polio — from 79% in 1966 to 66% in 1970.

Measles — There has been a sharp reversal of earlier success in community programs to check measles. In the first five years after the introduction of measles vaccine, the number of cases in the United States declined from 458,000 in 1964 to 22,000 in 1968. This figure, however, more than doubled in 1970. Dr. Witte expressed the belief that measles now is out of control.

In Alaska, there were only 11 cases of measles in epidemiologic year 1968-69, but this jumped to 145 cases in epidemiologic year 1969-70, an increase of 1318% (as contrasted with a nation-wide increase of 90%).

Studies of outbreaks in six places, where measles was suspected to have occurred in previously vaccinated children, disclosed a conspicuous difference in attack rate between those previously vaccinated and those who had not been, with the result that the vaccine was computed to have efficacy of 90 to 98%. Analysis disclosed also that in urban areas, measles is found especially amongst children up to age four, while in rural areas the highest incidence is amongst children aged five to nine years. A study in Los Angeles County disclosed that measles hits hardest in the lower socio-economic groups.

To control outbreaks of measles, Dr. Foege recommended that each epidemic be studied, control measures undertaken, and thus the spread can be interrupted.

German Measles — The epidemic of 1964 has been estimated to have affected 50,000 pregnancies at a cost of \$840,000,000.

Rubella vaccine was first licensed in June 1969. The target has been children aged one to 12, with especial emphasis on those aged five to nine. Over 20 million children have been immunized. By January 31, 1971, 82% of the target population in Alaska had been inoculated. The number of cases of rubella in Alaska dropped 89% between 1969-70 and 1970-71. In 1970, Alaska had one known case of congenital rubella.

Three kinds of vaccine have been licensed: duck embryo type, dog kidney type, and Cendehill strain. Reactions to the rubella vaccination were

discussed by Dr. Shelby A. Wyll, Acting Chief of the Field Evaluations and Investigations Section. Reactions have been noted especially with the dog kidney vaccine. They have occurred in 6 to 13% of the inoculations, and have been observed from the first to the ninth week after immunization, with the peak occurring at the fourth week. Usually, the reaction lasts only a few days. The symptoms usually consist of transient joint pains (affecting especially the hands, wrists and knees), paresthesias, and occasionally a rash and lymphadenopathy. Women are more likely to have reactions than children: about one-third of adult women who are immunized may develop reactions.

Concern has been expressed about situations where unintentionally a female is immunized against rubella while she is pregnant. It has been found that the virus can infect the decidua and placenta. One study pertained to 12 susceptible women who received rubella vaccination immediately before or during pregnancy. Half the women gave birth to babies clinically normal at birth. Two women aborted spontaneously. Of the four women who underwent therapeutic abortion, three had histo-pathologic changes in tissue. The virus was recovered from the placenta in two instances and from the decidual tissue in two instances.

Any adolescent girl or adult woman should have the HI Test for rubella antibodies before rubella immunization is administered.

Some virus shedding occurs 7-28 days after individuals receive rubella vaccination: the virus has been detected in the pharynx. However, it is felt that the vaccine rarely is transmitted to others from an immunized individual.

With 3,700,000 live births per year, the United States can be expected to have 740 children with congenital rubella, which may produce cataracts, congenital heart disease and deafness.

Combined Vaccines are anticipated by Fall, containing either measles and mumps vaccine or a combination of measles, rubella and mumps vaccine.

Hepatitis — Dr. Saul Krugman discussed the distinctions between MS-1 (infectious hepatitis) and MS-2. The latter has a parenteral incubation time of 46 to 91 days and an incubation time of 88 to 108 days when transmitted orally. Gamma globulin protects only against MS-1, the more contagious form. Neither type provides immunity against the other form.

Rh Hemolytic Disease was discussed by Dr. Richard G. Judelsohn, Medical Epidemiologist, who reported 20,000 infants are affected each year. He urged administration of RhoGam 24 hours post-partum to Rh-negative women and also if they receive an Rh-positive transfusion.



THE ROLE OF PROFESSIONALS IN WORKING WITH UNWED MOTHERS AND CHILDLESS COUPLES

By Sister Mary Clare, A.C.S.W.

*Director, Catholic Charities Family
and Children's Services
Anchorage, Alaska*

An unwed mother struggling with many questions and decisions needs three distinct kinds of professional services — medical, social, and legal services. The childless couple confronting infertility also needs professional services from these three major disciplines.

THE UNWED MOTHER

It has been said that one of the most salient features of the services available to unwed mothers is that the babies are objects of the most careful and thorough services while the mother, who may have even greater needs, is frequently offered something of a bandaid approach at the time of immediate pain. In order to really serve the unwed mother, services which provide treatment when she has the greatest need for psychological care must be more seriously considered. The question arises, Who — or what agency — should be involved at this crucial time? According to the June, 1964 issue of *Child Welfare*, "The need for close cooperation between the physician the social worker and the lawyers in the case of the unmarried mother should be universally recognized. Each of these three is responsible for advising the unmarried mother of the need for consultation in her case with the other two disciplines involved, because each has a special field of competence."¹ The physician should offer his medical expertise, the social worker his emotional support, and the lawyer his legal counsel.

We know that our Alaskan laws do not prohibit the handling of adoptions through physicians and lawyers. At one point in our history, these two disciplines could boast of their work in this field, since there were available babies for prospective couples, and the placement of children was easily and quickly facilitated. Many children today would have been deprived of having homes if adoptions had depended on the Department of Health and Welfare, as they were crippled with insufficient staff and funding to meet one of Alaska's priority needs. Adoptions through these alternate sources was therefore acceptable.

However, Catholic Charities Family and Children's Services, a multi-purpose, non-profit, non-sectarian agency, now offers Alaska a program of services to the unwed mother and to adoptive couples.

As a licensed agency, we have to date placed 115 children; of these, there were 79 Caucasian, 29 Native, and 7 Negro. Not all of these children, however, were Alaskan babies: 31 were made available by Washington agencies such as Seattle Catholic Charities, Medina Children's Services, and Lutheran Family Services, and three infants came from Canada. There were a total of 30 made available through the Alaska Department of Health and Welfare, and the remaining 51 were babies relinquished by girls personally counseled through our agency. We have studied homes of various religious affiliations — Catholic, Protestant and Jewish, as well as those of liberal religious persuasion. The wishes of the natural mother in the area of religion and type of family she desires for her child are always honored by our staff.

In the four years of our operation in the State of Alaska, our agency has reached only 51 unwed mothers. For four years of service, this figure is low, and there are several reasons for this: Many girls do not know of our services; doctors and lawyers have been largely unaware that a new agency had been established; and many of these professionals have felt that they could adequately facilitate an adoption without the cumbersome procedures required by public and private agencies.

The young woman who finds herself pregnant out of wedlock is faced with many problems — psychological, financial and emotional. We feel she is in desperate need of the services available through a social service agency, and without these services, she suffers. Let me illustrate.

"Lisa," age 15, was referred to our agency by a local doctor who believed further counseling was required for added support of his young patient. When Lisa — confused and hostile — kept her initial appointment, she had not yet informed her parents about her pregnancy of approximately three months. Questions plagued her: Should she

tell her parents? Should she drop out of school? Should she get an abortion? Should the putative father help with expenses? Should she keep her baby? Should she consider relinquishment and adoption?

It is a known fact that pregnancy is a period when the style of ego functioning changes in every woman. Gerald Caplan has some of the most interesting statements on pregnancy and on the nature of ego functioning at the time of crisis. In his book, *An Approach to Community Mental Health*, he discusses the nature of "normal" crisis in the human experience. Examples of "normal" crises are adolescence, marriage, pregnancy, and the death of a loved one.² Caplan, like Erik Erikson, describes these life crises as the significant times when an individual's emotional equilibrium is disturbed. As a response to dis-equilibrium, the ego develops new ways of adapting to crisis. If psychological crisis work is inadequate, the person will regress emotionally to seek equilibrium.

It is important therefore, in handling a case like Lisa's, to be acutely conscious that, in order to be successful, the support given at this crisis period must assist the girl in her return to a higher level, rather than allow possible regression to seek stability. Lisa, through a series of weekly counseling sessions, worked through many feelings such as hostility toward her father. She also began to see her mother differently who, in turn, began to understand her own "confused child." Lisa was happy to know she did not have to leave Alaska, and was able to attend classes as set up by the Anchorage School District. Financially, her family could not meet the heavy medical expenses, but by referral to the Department of Health and Welfare, expenses were paid.

As the many initial stresses facing this girl gradually diminished, Lisa began looking to herself as a person. At this point in the counseling process, emotional growth becomes evident — growth which could have become immobilized if worry had persisted in Lisa's life. In this case, however, with all parties jointly concerned about her welfare, it was gratifying to see her subsequent adjustment to her family, her school, and to herself.

On another occasion, I was called to the hospital room of a young girl, "Millie," 21 years of age. Upon entering the room, the girl gave me a weak smile and within a short time was able to verbalize her story. She related that when she first learned she was pregnant, she felt she should leave her hometown to avoid discovery by her parents. She remembered two former acquaintances — a young military couple who lived in Anchorage — and decided to join them. When she arrived, six months pregnant, they advised her to contact a lawyer, who subsequently promised to place her

child. At this point in her story, the girl broke down and sobbed, "Tomorrow I'm going to relinquish my baby and I don't even know where my child is going. I haven't seen the lawyer now for three months."

After talking to this girl for only an hour, I began to realize the potential damage that can be caused by lawyers who fail to meet the needs of their unwed mothers. Even under normal circumstances, pregnancy is a period of increased susceptibility to crisis; add to this the fact of meeting such a crisis alone, and there exists the distinct possibility that the girl will never make a satisfactory adjustment to placing her child for adoption, and this unresolved dilemma may haunt her for the rest of her life.

The girls who have probably most benefited by the services of our agency are those who are 19 years of age and older. Girls in their early teens can usually adjust to a home for unwed mothers more easily than those in their early 20's. When a referral is made to Booth Memorial Home, the girls are placed in the competent hands of counselors trained to guide these girls toward mature decisions. If families request referrals outside the State of Alaska, this can also be arranged. And it is certainly gratifying to receive letters from former unwed mothers who are now in healthy, happy marriages — girls who have successfully adjusted after a serious confrontation with life.

Since the passage of our liberal abortion bill in Alaska, abortions are a daily occurrence. One question must be considered: Are the young mothers — and their parents and physicians — fully cognizant of the long-term implications of abortion? "Getting rid of the problem" — that is, the unborn child — may well create even greater psychological stresses for the mother and her family. Perhaps the two greatest traumas that can occur in a woman's life are aborting an unborn child, and relinquishing a child after birth. A decision to abort a pregnancy must necessarily be made quickly, within a brief period of time. With the frightening discovery of an unwanted pregnancy, hasty and irreversible decisions are often made without benefit of wise counsel.

On the other hand, when a girl plans to see her pregnancy through to its termination, she has several months to consider relinquishment, and can have better opportunity to really plan for her child — whether it be to keep the baby or to release him for adoption. The following incident, adapted from an article in *Catholic Charities Review*, may best reinforce the importance of necessary abortion counseling.³

"Mary," more than five months pregnant, arrived in New York from her home state of Florida for the purpose of aborting her pregnancy. Her appointment was with a doctor who made

light of the physical trauma of abortion. He made arrangements for Mary's hospitalization and informed her that she would be able to return to work in Florida in approximately a week.

Having second thoughts on her decision to abort, however, Mary chose to go to a private agency and "talk things out." She stated that she had learned of the doctor's services through an advertisement in a Florida paper, and it was evident that she knew nothing of the doctor or the procedures of abortion. It also became apparent that Mary had moral qualms about this course of action which stemmed from her upbringing.

Medical information indicates that vacuum abortion cannot be performed after the third month of pregnancy; the method advised for girls in Mary's situation is the saline injection in which salt solution is injected into the uterus. Abortion of this kind indicates probable emotional as well as physical trauma. Labor is actually induced, and the ejected fetus remains with the mother until the placenta is discharged. The fetus at this point is a formed infant capable of sustaining life and, according to reputable sources, doctors are required to file both a birth certificate and a death certificate.

Mary was informed of these facts and was also made aware of some alternatives to abortion: adoption, foster placement, and day care. She was told that she could receive help from a Catholic Charities agency in Florida, and was given the address of the office in her home town. She returned to Florida where she plans to have and keep her child.

We relate this incident to emphasize the fact that, as a service agency to unmarried pregnant women, we try to help them make adequate plans for themselves and their children. We do not impose judgements of "right" or "wrong" — we simply believe it is our duty to make each girl aware of all the alternatives and facilities available to them in making their decisions.

THE CHILDLESS COUPLE

Many people today are unaware of the adoption picture in Alaska and throughout the nation. All agencies in recent months have experienced a marked reduction in the number of healthy, Caucasian infants in need of placement due primarily to widespread use of the Pill, liberalized abortion laws, and the current trend of girls keeping their babies. This leaves adoption agencies with an interesting dilemma: what to do about adoptive applicants desiring such children. At present, our agency has families approved for placement of full-Caucasian children, but we have no children available. Those couples requesting Native, Negro or part-Negro children, however, have a much shorter waiting period since these children are available for adoption.

Exciting things have been happening at Family and Children's Services in its adoption program. Using our local newspaper media, we have made appeals to help place the "undesirable" children — those considered hard-to-place because of racial background, physical or mental handicaps, or age. Couples have answered our appeals, and we see a hopeful future for these youngsters. It should be understood, however, that Alaska has very few older children available for adoption, and it is necessary to work through "Outside" agencies. We are currently involved with ARENA (Adoption Resource Exchange of North America) in obtaining the older child.

The adoption of a child with special needs emphasized the necessity of a home study in order to safeguard the primary client — the child. An adoption study is no longer considered by our staff as merely an investigative, critical observation of the family wishing to receive the child; it is an educational process which assures the couple of professional help with any adjustment problems which might arise, particularly where the hard-to-place child is involved.

There are no absolute standards when it comes to judging whether certain people will make good adoptive parents. In the past, agencies stressed age, finances, race, nationality, religion and a "matching" of physical characteristics. Today, however, adoption agencies have re-evaluated their procedures, realizing the importance of more essential considerations, such as finding the "right" home for a given child — a home that will meet the emotional and psychological needs of the particular child.

A bill introduced this year in Alaska's legislature offers protection for the child placed for adoption, as it will require an investigation of the home situation by a qualified social worker, before the adoption can be finalized. The inclusion of this legislation would help to insure the child of a good home, as every minor child who goes into a home as a total stranger would receive adequate recognition by the State before the final commitment as to his future status is made. Hopefully, this bill will pass the legislature next year.

Alaska's private adoptions far exceed those of other states. Nationally, two-thirds of all non-relative adoptions in 1969 were arranged by social agencies. In 1969, agency placements comprised 90% or more of all non-relative adoptions in 11 states, but 65% or less in nine states including Alaska and Puerto Rico, where independent placements considerably exceeded agency placements. In Alaska only one-fifth of all non-relative adoptions are arranged through agencies.

SUMMARY

The question I feel we must ask ourselves as professionals is this: Are we being fair to the unmarried parent or the adoptive couple? Is each discipline — the doctor, the social worker and the lawyer — using his individual area of competence in genuinely assisting his patient? All these disciplines need to cooperate, as finding adequate homes for children is essential. Agency adoptive parents may not necessarily prove to be better parents, but it would seem advisable that the best possible homes be obtained for the few children who are available for placement. Screening adoptive applicants helps to insure their suitability as parents — it does not guarantee success but it diminishes chances of failure. Perhaps this is the time for doctors and lawyers to follow the standards set up by the Child Welfare Association which states:

Towards this end, the Child Welfare League of America urges that a social study be made of all

non-agency placements, including step-parent and other relative adoptions. This study should be required by law, should be made by the State Department of Welfare or an agency designated by it, and should be carried out by skilled professional personnel.⁴

Perhaps this is the time.

FOOTNOTES

1. *Child Welfare*, June 1964, "A Guide for Collaboration of Physician, Social Worker, and Lawyer in Helping the Unmarried Mother."

2. Gerald Caplan, *An Approach to Community Mental Health*, Grune and Stratton, New York, 1966.

3. The Catholic Charities Review, March 1971, Vol. LV, No. 3. "In Focus: The Parentless Child, and Childless Parent, and a Blind Date (Catholic Home Bureau "Newspaper")."

4. *Guidelines for Adoption Service*, Child Welfare League of America, Inc., 1971, New York. Sally P. Ford, Consultant.

COMMENT

Almost everyone agrees that careful, kindly social service investigation and recommendation is desirable before adoption, even though many happy placements have been worked out in the past between the mother, the adopting parents, the physician, and an attorney.

We all know that the Family and Children's Service of Catholic Charities does fine work in adoptions, but wonder sometimes if such an organization can be entirely detached and fair with respect to the matter of religious affiliation or, for that matter, absence of religious affiliation of prospective adopting parents. It might not be wise, therefore, to make Catholic Charities the exclusive agent of the State in private adoptions.

The number of newborns needing adoption is dwindling. When are we going to face the larger need to encourage adoption of older children from broken or inadequate homes?

— Rodman Wilson, M.D.

MUKTUK MORSELS

By Bob Ogden

ANCHORAGE:

Physicians in Anchorage are on the move, office addresses are changing daily. The new Providence Hospital Professional Building, 3300 Providence Avenue, has been completed and 30 physicians have moved or are moving in. If you've lost the new address of your colleagues, call the medical society for address changes (277-6891).

DR. CHARLES H. MOSELEY has established an office at 207 E. Northern Lights in General Practice.

DR. WON PAL CHUNG has recently opened his practice of General Surgery and Proctology at 207 E. Northern Lights Blvd. Dr. Chung practiced in Nome for 2 years.

DR. GUY S. CLARK has joined the Anchorage Medical and Surgical Clinic, 718 K Street, in the practice of Internal Medicine and Rheumatology.

DR. LAURENCE A MARSHBURN has joined the Lake Otis Clinic, 4050 Lake Otis Parkway, in General Practice. Dr. Washburn was most recently a flight surgeon at Elmendorf Hospital.

DR. WILLIAM S. STOVER began the practice of Orthopedics in the Lake Otis Clinic. He was formerly stationed at Elmendorf Hospital.

DR. JAMES SWARR began the practice of Ophthalmology at 825 L Street. Dr. Swarr is Board eligible in ophthalmology and is from Pennsylvania. He recently completed his ophthalmology residency at the Massachusetts Eye and Ear Infirmary. Dr. Swarr was formerly with USPHS in Alaska.

The Alaska Clinic has had or will soon have five new physicians joining them: DR. RAY GILLS, Board Certified OB-GYN, who was practicing at the Elmendorf A.F.B. Hospital for the last three years. DR. CHARLES WALLNER, Board Certified OB-GYN, was recently discharged from the Army at Fort Ord. DR. GEORGE STUART, internal medicine-pulmonary diseases, recently completed his residency in internal medicine at the Virginia Mason Clinic. DR. THOMAS WOOD, internal medicine-cardiology, recently completed an internal medicine residency at the University of Washington. DR. DALE WEBB, internal medicine-hematology recently discharged from the Army in San Francisco.

DR. GARY ARCHER of the Alaska Clinic left July 1 to complete a fellowship in cardiology in the Department of Medicine, University of Washington. Dr. Archer will be gone one year.

DR. AND MRS. RICHARD W. CURTIS recently had a baby girl.

DR. VELMA ELIZABETH COFFIN-KWART, P. O. Box 395, Woomera, South Australia, 5720, formerly with the USPHS in Alaska, is enjoying private practice in the Australian outback. She promises us an article on her experiences.

FAIRBANKS:

DR. JOSEPH K. JOHNSON was elected President-Elect of the Alaska State Medical Association during the ASMA's annual meeting.

DR. JOSEPH RIBAR was re-elected as ASMA's AMA Delegate and was elected Vice-Chairman of the State Comprehensive Health Planning Council.

DR. GEORGE B. MURPHY of Texas has joined the Fairbanks Medical Surgical Clinic after some years with the Gundersen Clinic in LaCrosse, Wisconsin. Dr. Murphy is Board certified in General Surgery.

DR. TAYLOR MARROW has left the Fairbanks Medical and Surgical Clinic and is practicing in Idaho.

DR. PHILIP W. HARDIE has returned to the Fairbanks Medical and Surgical Clinic after a brief employment with the Department of Health, Honolulu, Hawaii. Dr. Hardie is formerly the hospital commander of Bassett Army Hospital in Fairbanks.

HAINES:

DR. STANLEY JONES was recently appointed to the State Board of Medical Examiners by Governor Egan.

KENAI-SOLDOTNA:

DR. PETER HANSEN has a new associate in General Practice, DR. TED LUND from Iowa.

The 30-bed Central Peninsula Hospital is now open. The hospital is administered by Lutheran Hospitals and Homes Society. The same group provides administrative services to the Fairbanks General Hospital.

JUNEAU:

The physicians of the Juneau Medical Society are to be congratulated for the job well done in preparing and presenting the annual meeting of the ASMA.

DR. ROBERT CAVITT is not leaving Juneau. He will be continuing his practice in General Surgery at 10 Highland Drive.

ALASKA STATE MEDICAL ASSOCIATION

26th ANNUAL MEETING JUNEAU, ALASKA

The Juneau Medical Society, especially Gary Hedges, M.D., Convention Chairman, were commended by the Alaska State Medical Association's House of Delegates for the splendid annual meeting June 9-11, 1971.

Eighty physicians, fifty-two exhibitors representing thirty-five companies, and thirty guests (nurses, physician's wives, para-medical personnel, etc.) attended the three day annual meeting.

Edward Spencer, M.D., from Sitka, 1970-71 Alaska State Medical Association President, presented the Physician-of-the-Year award and Community Service award during the annual banquet.



Dr. Paul Eneboe, Physician of Year 1971.

Paul Eneboe, M.D., of Homer, received the Physician-of-the-Year award for his work as the chairman of the ASMA's Bush Medicine-Public Health Committee. As the chairman, Dr. Eneboe has been successful in having his committee recognized as the forum for health agencies and organizations in Alaska. The major federal, state and private organizations concerned with health in Alaska are represented on his committee either as physician members or through ex-officio representation.

Through numerous meetings of the Bush Medicine-Public Health Committee, common positions have been reached on many health issues and inter-agency communication has improved greatly.

Through the work of Dr. Eneboe and his Committee, the ASMA has become recognized as a

major health voice in Alaska. Many who ignored the Association in the past have come to request ASMA opinions on issues of importance.



Dr. and Mrs. Arthur Schaible, Community Service Award.

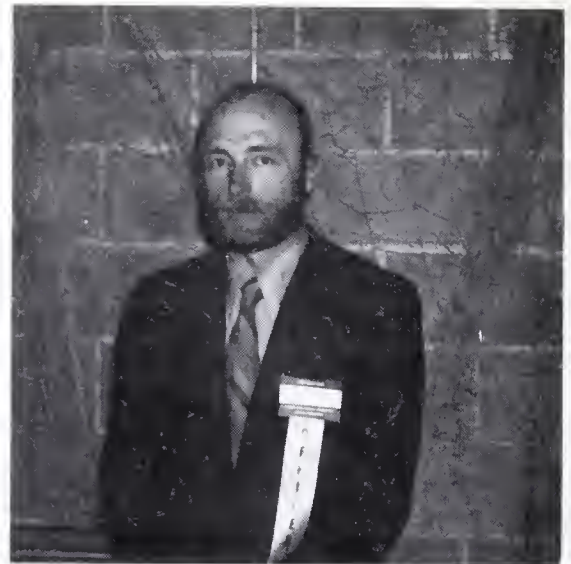
Arthur Schaible, M.D., of Fairbanks, received the A. H. Robins Community Service Award for his years of service in Fairbanks. Dr. Schaible began his practice in Alaska in 1938, first with the Alaska Native Health Service Hospital in Tanana. From 1938-41 Dr. Schaible provided medical care to all the villages up and down the Yukon River from Northway to Marshall. In 1941 Dr. Schaible came to Fairbanks and joined the Fairbanks Medical and Surgical Clinic. Since beginning practice in Fairbanks, Dr. Schaible has continually been active in community service endeavors. Some of his activities have been Deputy Commissioner of Health for Interior Alaska, member Board of Health and Water Pollution Control Commission, member Alaska State Board of Medical Examiners, member State and Territorial Hospital Advisory Council, 8 year member of the Board of Regents of the University of Alaska, and one of the original organizers of the Alaska Territorial Medical Association.

Dr. Schaible is retiring from medical practice in 1971 and will be recorded as one of the giants of early medical practice in Alaska.

J. Ray Langdon, M.D., the new president of the ASMA presented Dr. Edward Spencer, the immediate past president, a plaque of appreciation for his many years of service to the ASMA.



Dr. and Mrs. Ed Spencer, Immediate Past President.



Keith Brownsberger, M.D., — Anchorage Councilor and ALPAC Chairman.



Gary Hedges, M.D. — Juneau Convention Chairman.



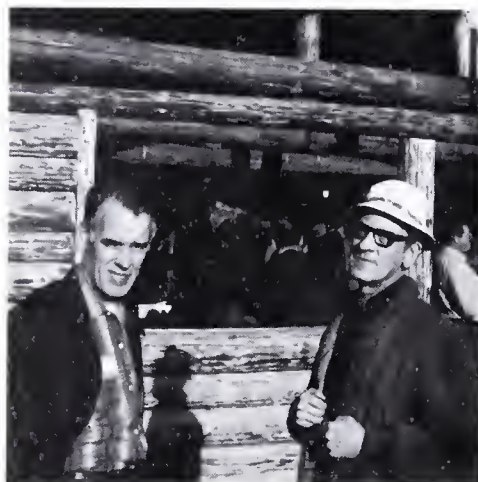
Enjoying the Beach Party — Henry I. Akiyama, M.D., — Juneau; Glen Crawford, M.D., — Anchorage.



Engrossed in Political Action (ALPAC), Aron Wolf, M.D., — Anchorage; Stan Jones, M.D., — Haines; Bob Billings, M.D., — Anchorage;



Some of the Fairbanks Delegation. Arthur Schaible, M.D., Joe Ribar, M.D., James Lundquist, M.D., (where are their proxies?)



Were they discussing Legislation or Fishing? Don Freedman, M.D., — Juneau; Rod Wilson, M.D., — Anchorage.



Milo Fritz, M.D., — Anchorage; J. Ray Langdon, M.D., President 1971-72, Anchorage; Jon Aase, M.D., — Anchorage.

On Friday June 11, 1971 new Association officers were elected:

J. Ray Langdon, M.D., Anchorage — President
Joseph K. Johnson, M.D., Fairbanks — President Elect

Paul E. Eneboe, M.D., Homer - Vice President
Robert B. Wilkins, M.D., Anchorage — Secretary-Treasurer

Joseph Ribar, M.D., Fairbanks — AMA Delegate

Councilors elected by their local society to represent them on the ASMA's Council (Board of Directors):

Anchorage:	Juneau:
Frederick R. Hood, Jr., M.D.	John Dalton, M.D.
Glenn Crawford, N.D.	
Keith Brownsberger, M.D.	
Tom Harrison, M.D.	Ketchikan:
John F. Seldon, M.D.	James W. Mortensen, M.D.

Fairbanks:	Kenai Peninsula:
William F. Kinn, M.D.	Vacant
Ray Evans, M.D.	

The scientific sessions and exhibits were well attended and the ASMA was again fortunate to have outstanding speakers.

The ASMA's House of Delegates adopted 21 resolutions. The adopted resolutions are listed as follows, at least by title and in some cases in total. (Copies of all resolutions are available at the ASMA office):

3-71 HEALTH MANPOWER COMMISSION

In order to care for individuals in small communities and in remote work sites, medical assistants working under the remote supervision of physicians are needed.

RESOLVED, that a Health Manpower Commission be formed by the Alaska State Medical Association to recruit, distribute, supervise and regulate medical assistants for small communities and remote work sites.

6-71 LICENSING OF HEALTH PROFESSIONALS (See letters to Editor).

8-71 USE OF CONTROLLED DRUGS

The medical profession has long taken the stand that physicians by training and by ethical standards are the only logical persons to prescribe drugs. We have rightly attempted to resist efforts of government to narrow our prerogatives, and we have also resisted efforts of other, non-medically trained groups to utilize these potent preparations.

Therefore, when some of us are careless or worse than careless in prescribing medication, especially psychoactive drugs, it behooves the Association to speak out in affirmation of our ethical standards against the prescription of large or open-ended amounts of sedatives, tranquilizers and stimulants and against the illegal prescription of narcotics to maintain addiction.

RESOLVED, that the Alaska State Medical Association reaffirm its condemnation of illegal prescription of narcotic drugs to maintain addiction and condemns the prescription of large, open-ended amounts of sedative, stimulant, or other psychoactive drugs, and

RESOLVED, that this resolution be transmitted to the Alaska Pharmaceutical Association, the U. S. Bureau of Narcotics and Dangerous Drugs, the Alaska State Department of Health and Welfare, Alaska Native Health Service, and the U. S. Congressional delegation.

12-71 FLUORIDATION OF WATER

RESOLVED, that the Alaska State Medical Association favors fluoridation of public water supplies wherever water does not naturally contain fluoride sufficient to prevent tooth decay.

14-71 PHYSICIANS FOR NOME

RESOLVED, that the United States Public Health Service assign a physician or physicians to Nome so long as the need exists.

16-71 PROTECTING THE PUBLIC FROM ILL PHYSICIANS

21-71 PATHS FOR PEDESTRIANS, SKIERS, AND BICYCLERS

Exercise, clean air, and absence of noise are good for health. Planners of surface transportation routes appear systematically to have eliminated sidewalks, paths, and crossings of roadways, so that it is difficult or impossible to walk, ski, or bicycle to school or work. Because of this, more and more motorized vehicles foul our lives.

RESOLVED, that the Alaska State Medical Association vigorously support non-motorized self-propulsion as good for health, and

RESOLVED, that the Alaska State Medical Association ask legislators and planners of surface routes to develop paths, cycleways and safe crossways for pedestrians, skiers, and bicyclers.

22-71 CONDEMNING INSURANCE COMPANIES FOR DEMANDING COPIES OF OFFICE CHART NOTES

Insurance companies are increasingly demanding exact copies of private medical office patient chart notes in processing medical claims. Chart notes often contain confidential information which the insurance carrier does not need and has no right to see.

RESOLVED, that the Alaska State Medical Association condemn this practice as a depersonalizing, unnecessary invasion of the physician-patient relationship, and

RESOLVED, that the Association

1. Send copies of this resolution to insurance carriers.
2. Make copies of the resolution for members to attach to insurance forms.
3. Tell the public through news media that insurance companies are invading the doctor-patient relationship when they demand copies of office records.

23-71 ARCTIC HEALTH RESEARCH CENTER

RESOLVED, that the Alaska State Medical Association urges continuation of all the activities of the Arctic Health Research Center.

24-71 MEDEX PROGRAM

RESOLVED, that an invitation be extended to Richard Smith, M.D., Director of MEDEX, to work with the Alaska State Medical Association and other appropriate agencies to develop a MEDEX program in Alaska.

25-71 VENEREAL DISEASE

RESOLVED, that the Alaska State Medical Association notes with concern the increasing prevalence of venereal disease in Alaska and urges the State to develop a more elaborate, more effective, and fully funded program to control these hazardous diseases.

26-71 THE ALASKA PROJECT FOR THE IMPROVEMENT OF HEALTH CARE

RESOLVED, that the Alaska State Medical Association supports the Alaska Project for the Improvement of Health Care and urges the Commissioner of Health and Welfare to pursue federal funding of this project and its implementation at an early date.

27-71 MEDICREDIT

RESOLVED, that the Alaska State Medical Association endorse the American Medical Association's Medigap plan.

30-71 COMMENDATION TO THE JUNEAU MEDICAL SOCIETY

31-71 EXPRESSION OF GRATITUDE TO EXHIBITORS

33-71 HOUSE OF DELEGATES

The workload of the House of Delegates has increased yearly, leaving less time for in-depth consideration of important issues. Further, the time spent at the House of Delegates meetings has been increasingly eroded by presentations from various agencies, organizations and groups with pertinent health interest.

The Alaska State Medical Association has now grown to the point where appropriate committees can perform much of the work.

THEREFORE BE IT RESOLVED, that the time spent in the House of Delegates meetings be devoted to consideration of resolutions, committee reports, election of officers, and other appropriate Alaska State Medical Association business, unless otherwise directed by the President, and

BE IT FURTHER RESOLVED, that presentations by agencies, groups and organizations be assigned to appropriate committees for in-depth discussion, consideration, and then presentation to the House of Delegates via committee report and/or resolution, unless otherwise directed by the President.

34-71 MATANUSKA VALLEY CHILD CARE FACILITY

RESOLVED, that the presently available Alaska Children's Services' beds for disturbed children be utilized to their fullest extent, and that Division of Public Welfare plans for a Palmer child care facility and program be modified to provide family-centered programs to prevent emotional disturbances and delinquency from before the age of 8 years.

35-71 FINANCIAL SUPPORT BY THE STATE FOR AREA COMPREHENSIVE PLANNING

RESOLVED, that the Alaska State Medical Association recommend the State make funds available for P.L. 89-749 314 B agency formation (area wide health planning agencies).

38-71 NURSING EDUCATION

RESOLVED, that the Alaska State Medical Association support the concept of progressive nursing education wherein accumulated courses, experiences, and academic credit may be used to reduce and satisfy the requirements for associate and graduate degrees.

39-71 SUPPORT FOR WAMI

41-71 LEGALIZING THE USE OF MARIHUANA

The problem of abuse of legal and illegal drugs is serious. Misinformation has added to the problem.

RESOLVED, the Alaska State Medical Association Legislative Committee in cooperation with other committees, such as the Mental Health Committee, is requested to investigate the problem, and, if warranted, develop legislation to legalize the use of marihuana.

FURTHER RESOLVED, that the Legislative Committee render its recommendations to the House of Delegates or to the Council for its action regarding the implementation of its recommendations.



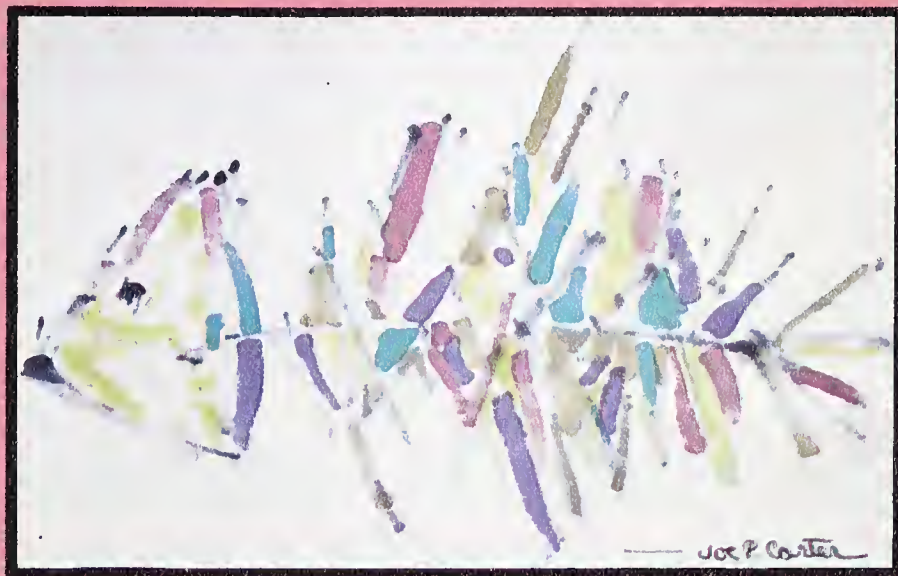
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NOV 23 1971



ALASKA Medicine

Volume 13, Number 4, October 1971



Patients fell asleep quickly

Dalmane (flurazepam HCl) 30 mg reduced awake time—both before and after falling asleep - by fifty percent of pretreatment values in patients with insomnia.^{1,2}

Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electroencephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

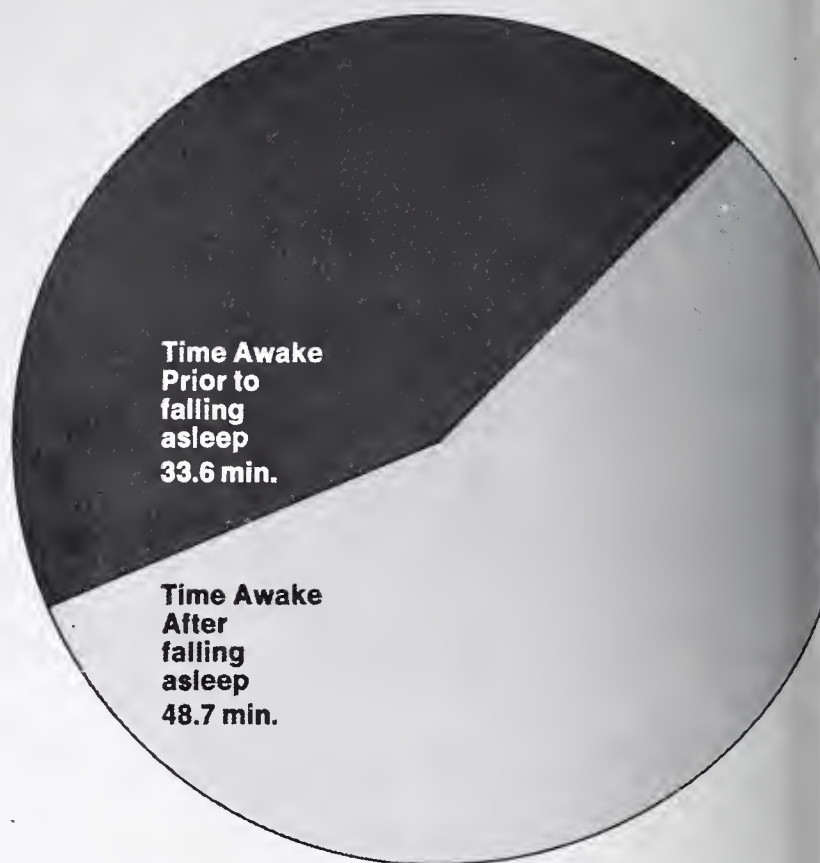
Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.

2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

Before
Dalmane
(flurazepam HCl)



LETTERS TO THE EDITOR

Every American Has a Right!

Dear Sir,

I share your concern regarding providing for the demonstrated health needs in America in view of the lack of available health resources. I personally however, feel responsible for making an attempt to solve the inadequacies in our present health care system as I feel that "every American has a *right* to receive good ambulatory and hospital care."

I am disturbed by your essay recently in the Alaska Medicine titled, "Every American has a Right to Health Care." You demonstrate inadequate knowledge of two of the three broad categories of health care you discuss. You neglect to objectively evaluate private medicine which is where your expertise lies.

Government sponsored medical programs are so varied that it is senseless to generalize about one type of "Government medicine." It is fair to observe that each broad category of government medicine has historically evolved to guarantee health care to a specific group of people who did not have an adequate health care system available to them. The Alaska Natives are the most pertinent such group to our discussion. There is no question that by all parameters of measuring the health status of a population that the health status of the Alaska Native has improved dramatically in the past 15 years.

The rewards, salaries, and incentives are different in each branch of government medicine. A recent AMA survey has shown that salaried physicians do work fewer hours per week. However, do not confuse working hard and the efficiency of an individual with the efficient delivery of health care to a group of people. The topnotch care given by many physicians in the Native Health Service is based on individual initiative and effort. The result is the same as you find in private medicine. The rewards are not necessarily financial.

The Kaiser-Permanente Health Plan is much too sophisticated to be dealt with in the cursory manner which you have done. I suggest that you read a monograph by Greer Williams of the Tufts School of Medicine titled "Kaiser-Permanente Health Plan-Why it Works."

The issue is not government medicine against private medicine or against Kaiser-Permanente. The issue and the challenge is in developing a system which ensures that health services are available for our population. Topnotch quality health care is compatible with all three categories of health care which you have specified and *is* present in all three categories.

I would enjoy discussing these issues with you. We have a great need in the Anchorage area to develop a system of health care which includes everyone. At this point there are large segments of the population who do not have reasonable access to medical care. What are you going to do about it?

Sincerely yours,

Paul R. Duncan, M.D.
Alaska Native Medical Center
Outpatient and Field Health

Dr. Duncan has issued a challenge. We await reasoned solutions that might be palatable to free and honorable men. Will his cure be worse than the disease? Don't let your subscription lapse! — Ed.

On Autumn and Ears

Dear Sir,

Francis Bacon many years ago developed a scientific method so that the human frailties of emotion, prejudice and bias would not contaminate the process of reason.

Unfortunately, many physicians today have not only forgotten the art of medicine but have lost track of the science as well.

For example, the article entitled "St. Mary's Clinic" in the July issue of Alaska Medicine is a travesty of scientific publication: the rambling style of presentation where autumnal colors are mixed with draining ears is better suited to Reader's Digest whose readers would not question vague terminology such as "fancy" and "complicated" ear surgery. In 1957, when the radical mastoidectomy with Rambo closure were introduced into Alaska, a renaissance of otological philosophy had already blossomed in Germany where Zoller and Wullstein laid the foundations of tympanoplasty. Prior to the advent of antibiotics the orientation of the otolaryngologists was toward eradication of mastoid disease and its feared complications: the resultant surgery was necessarily radical and too often destructive of residual hearing.

With the evolution of surgical procedures to recover lost hearing from otosclerosis, a new role for ear surgery emerged and found its fruition in tympanoplasty: the concept of operative restoration of hearing loss in ears damaged by chronic infection.

The availability of antibiotics together with technological refinements such as the operating microscope made possible the repair of damaged ear drums, and the reconstruction of disrupted ossicular chains in chronically infected ears. Radical mastoidectomy has generally become *passee* for the chronic ear, with the exception of cholesteatomatous disease. The "Rambo Closure" has never been accepted as many otologists because it often hides the disease it professes to eliminate. An ear which has received a radical mastoidectomy and "Rambo closure" cannot be rehabilitated audilogically, i.e. the patient cannot wear a hearing aid. Patients who have received such surgery to both ears are functionally deaf. In 1971 this is no longer acceptable, even in Alaska where the "primitive conditions" of the bush are no longer of such magnitude as to deprive a child of his hearing. The problems of reconstructive ear surgery in the chronically infected Alaska Native ear are immense; their solution has evolved into a large scale program at ANMC in which already 1500 of the estimated 2500 diseased ears in native children have been rehabilitated. Based on 1500 cases a survival rate of 70% has been realized thus far; in ears receiving tympanoplasties this rate fluctuates enormously among villages and is most clearly a function of the socio-economic level of village life.

The failures of "fancy ear surgery" at St. Mary's are not to be minimized, but at the same time the gravity of prior otological surgery must not escape critical evaluation. Flippant statements such as: "the ear was restored . . . and the patient could swim, dive and carry on all the usual activities of youth" leaves out one rather important activity of youth which is the primary concern of otolaryngologists — namely hearing.

As the towering wave of reform breaks across the social, political, and economic institutions of this country that have long been buried in a slough of self satisfaction, the past has been washed clean, and its role has been given true perspective. Experience, tradition and habit are of

value when they provide a path for progress, but when they reach out to control the future they become tentacles of repression.

Sincerely yours,

J. David Williams, M.D.

P.S. The requirement of a summary at the beginning of each article would filter out its true factual content and make readily apparent those publications that would pretend to contain information dissolved in eddies of stylistic indulgence.

and Dr. Fritz replies.

Dear Sir,

In this letter I attempt to answer Dr. J. D. Williams taking me to task for some of the things I said in "St. Marys Clinic" appearing in the July 1971 issue of Alaska Medicine.

Apparently anyone who differs with Dr. Williams approach to eradication of suppuration in the temporal bone is guilty of emotion, prejudice, and bias. But by implying that I have "forgotten the art of medicine and lost track of science" he is guilty of administering as low an epistolary blow as good taste and civilized debate allow.

The title "St. Marys Clinic" betrays to the ready intelligence that what follows is not a scientific contribution but a medico-historical vignette. It clearly represents the observations of one physician. The observations on scenery and fishing while apparently exerting somewhat less than a fatal allure for Dr. Williams, to set the clinic in the perspective of village life for those who, in the future, might be interested in how things were at St. Marys in 1971.

Dr. Williams apparently does not realize that the performance of tympanoplasty, mastoidectomy or both depends on what is found at the operating table in the individual patient. If he reads with greater care the works of his mentors (Wullstein and Zollner) he will learn that frequently the surgeon who has planned, let us say, a tympanoplasty will occasionally have to do a radical mastoidectomy. On other occasions the plan to do a radical mastoidectomy may, happily and surprisingly, have to be scrapped in favor of a tympanoplasty alone or a simple or modified radical mastoidectomy in combination with a tympanoplasty. If temporal bone suppuration is complicated by certain types of cholesteatoma, facial paralysis, meningitis, septicemia or brain abscess, a radical mastoidectomy must be done and consideration of hearing becomes subordinate to saving the patient's life.

The radical mastoidectomy with a primary Rambo closure is for me the method of choice. Other surgeons use other techniques with equal success.

In the case mentioned I had done this operation on a six year old boy obtaining a dry comfortable ear. Ten years later a painless "lump" developed behind the ear. Then someone — could it have been Dr. Williams? — attempted removal of the lump and "restoration" of the middle ear resulting in the mess described. The boy asked if I could not "close" the ear again and free him from the fungating granuloma I described.

Simple removal of the cyst or cholesteatoma with primary closure would have resulted in the ear remaining dry instead of the unesthetic crippling mess that so sharply restricts the patient socially and scholastically.

Dr. Williams says the Rambo closure following a radical mastoidectomy only "hides the disease it proposes to eliminate." In his hands that is perhaps true. But Rambo

in his original article emphasizes that his procedure is not a substitute for meticulous, careful, complete removal of all pathology under the best magnification with the best instrumentation and illumination available.

The great thing about the Rambo closure of the external canal is that the patient can participate in every activity open to normal people without the ever-present likelihood of recurrent suppuration, malodorous discharge and its complications, often triggered when water accidentally gets into the ear. Only the immature, callous to the over-whelming desire of the young to do exactly what their peers consider fashionable, would ever describe the ability, following a successful Rambo closure, to swim and dive and carry on the usual activities of youth unimpeded by a stinking, discharging ear as "flippant".

The development and uses of modern hearing aids are frequently a disdained mystery to otherwise well trained otologists. Often they consider this important aspect of otology beneath their dignity. They refer the patient to a hearing aid technician or salesman for a fitting. Dr. Williams statement "an ear which has received a radical mastoidectomy and a Rambo closure cannot be rehabilitated audilogically i.e. the patient cannot wear a hearing aid" betrays ignorance that ill serves his patients and will haunt him to the days of his maturity.

For Dr. Williams information there is at least one patient whose record is available who had not one but two radical mastoidectomies with Rambo closures. He wears two hearing aids. They have enabled him to finish grammar school and to learn to speak intelligibly. He even has a job. His unaided hearing is actually better than pre-operatively. He no longer has the stinking aural discharge that made him a pariah.

I am flattered that Dr. Williams feels my modest contribution has the literary merit and interest worthy of being published in the Readers Digest. I wish the folks at Pleasantville felt the same way. Dr. Williams might do well attempting to reach this level of literary excellence.

In conclusion I suggest that when Dr. Williams no longer deals with a captive audience which one year is subjected to thousands of tonsillectomies and adenoidectomies, and the next to tympanoplasties on a massive scale, that his attitude will change. If it doesn't, he will never make the transition from monolithic medical bureaucracy to individual or group practice. If this transition is ever made, graphic illustration of his learning will not be represented so much by an upward curve as a line at right angles to the abscissa.

Sincerely yours

Milo H. Fritz, M.D.

Re: Medicine in Norway and Finland

Dear Sirs,

During the month of June, several Alaskans were fortunate enough to participate in the Second Circumpolar Health Conference in Oulu, Finland. This allowed an opportunity for a brief evaluation of health delivery systems in Norway and Finland.

During our tour, time was spent in central and regional hospitals and in peripheral medical centers. Many physicians who work in these various areas were interviewed.

NORWAY:

In Norway all people have government health insurance. This pays for in-patient services and 60% to 80% of out-patient care if obtained from the government sponsored medical service.

Private practice only accounts for 5% of services delivered, so our concentration will be on the governmental system.

The national government is responsible for administration of the insurance plan. (This is by income tax, 72% in the case of one young otolaryngologist.) The national government pays for construction of all medical facilities, from major central teaching hospitals to the remote health stations which are visited by regional doctors and nurses on a weekly basis.

The regional government (comparable to our state government) provides regional administration which analyzes health needs to ensure proper resource utilization.

The local government maintains the health facilities and hires the doctors and nurses to work in the hospitals and clinics.

The physician therefore works for the government in the large central hospital, in the smaller regional hospital, or in the local health station. The large central hospitals have all specialties represented. Usually they are associated with schools of medicine and nursing. These complexes range up to 1000 beds. The particular central hospital we toured was in Tromsø, Norway. This hospital is in a city of 90,000 and draws from a region of 200,000 people. Its first medical school class will enter this fall. Patients are admitted to the hospital on referral or through the hospital's own out-patient clinics.

The patient pays a small fixed daily amount for his in-patient care. This allows him a bed, procedures, physician consultation, and medicine. If he goes to the out-patient clinic, he pays the physician directly. The patient is later reimbursed for this by the government. The physician thus receives his pay in two ways. He gets a generous salary as compensation for his in-patient services. He also receives direct payment from the patient for out-patient care. The government also pays him a fee for each out-patient seen.

The physician appears to have 80% of his income fixed. He is allowed to make another 20% in private practice. All physicians interviewed were quite happy with this system and felt adequately compensated for time spent in their practice.

Within the health delivery system there was real identification of purpose based on accurate evaluation of needs on a regional basis. In the periphery, public health nursing programs and the use of mid-wives as para-medical personnel provide strong support of the service system, as well as an exceptional preventive medicine program.

Patients and physicians thus have free choice in their relationship. This system seems to be providing good health care with a satisfied provider and consumer.

FINLAND:

Finland has basically the same type of medical service organization as Norway, with several exceptions.

The small peripheral hospitals function more as community hospitals. Less serious medical problems are handled at this level rather than being referred.

The public health system run by the nurses provides some minimal direct health services in remote areas.

The patient pays a low fixed amount for in-patient and out-patient care directly to his physician, then is reimbursed by the government for 80% of the cost.

The physician is required to work 37 hours a week for the government. For this he gets a generous salary, vacation (6 weeks), and periodic sabbatical leave. He can receive money from private patients treated as in-patients or out-patients in the government facility. He may also spend about 6 hours a week in his private practice completely free of government control.

In Oulu, Finland, a community of some 90,000 persons, a regional medical hospital of 1000 beds is being built to provide service for some 500,000 people and training for 120 medical students a year. As a part of

medical education, each student must spend time in a remote community center. Thus he is aware of the complete health system and can look over areas where he might eventually practice. The latter is also true for students in Norway.

SUMMARY:

The medical systems of both Norway and Finland are founded on an accurate evaluation of needs. Coordination and concentration of medical resources in the health systems seem to lead to exceptional preventive programs and excellent medical facilities. The latter also allows medical training in the Northern regions which assures physician availability to answer the needs.

Satisfaction with both systems by physicians and patients is apparent, and might be due to the free choice each has in the physician-patient relationship.

Several other things seem to make the physicians happy in these systems. The physician is adequately compensated; he has direct and meaningful input into the planning of programs and facilities; these programs and construction projects occur on a scheduled basis which is realistic.

Such general satisfaction was not evident on talking to physicians from Sweden. The trouble with their system, which is totally socialistic, is that the physicians didn't or couldn't participate in planning. They now work in a politician-created system which is insensitive to the needs of patient and physician.

It would appear from my brief look at medical practice in Northern Europe, that American physicians should remain maximally involved in future medical program planning.

Sincerely yours,

David D. Beal, M.D

Re: Medical Assistants

Dear Sir,

Medical office and hospital personnel from Anchorage, Fairbanks, Glennallen, Juneau and Palmer attended a Summer Workshop sponsored by the Alaska State Society of the American Association of Medical Assistants at Anchorage Community College from June 18-30, 1971. Paramedical employees of Doctors Jon Aase, Gary Hedges, James Ivey, Jr., Perry Mead, William Reinbold, and the Alaska Clinic, Faith Hospital, Providence Hospital and the Tanana Valley Medical/Surgical Group were represented.

Meeting from 8 AM to 2 PM daily, each class began with study of medical terminology. Initial sessions were devoted to concentrated analyses of medical prefixes, suffixes and roots. Using Frenay's "Understanding Medical Terminology" as the student text, subsequent lessons explored the terminology of each body system. A full-size skeletal model loaned by Dr. Reinbold and a torso model gave every Workshop participant the opportunity to identify major structures.

Medical ethics were incorporated into the curriculum through detailed classroom discussion of the Principles of Medical Ethics augmented by published interpretations of the AMA Judicial Council.

During afternoon sessions, intensive lecture-discussion periods on Medical Law were offered. "Medicolegal Forms with Legal Analysis", prepared by the AMA's Law Department, was distributed as a reference. Some of the subjects covered included the legal relationship of physician to patient; professional and paramedical liability; privileged communication; informed and implied consent; proximate cause; and the legal doctrines of *respondeat superior* and *res ipsa loquitur*. Eight 16 mm. movies from the William S.

Merrell Company's "Medicolegal Film Series" were shown.

In the Workshop's second week, a field trip to the Alaska Psychiatric Institute supplemented classroom instruction on psychiatric disorders. Mrs. Mildred Mantle, Services Coordinator, and Jo-Carole Sikorski, Nursing Education Supervisor, conducted a briefing session. A tour of the wards was followed by lunch in the API "Snake Shack" where patients help prepare and serve the meals as an adjunct to their therapy.

Certificates of completion, documenting the students' special scholastic achievement, were presented to participants at a dinner held at the Holiday Inn on completion of the two-week Workshop.

Although students' backgrounds ranged from a Registered Nurse with many years' experience to an 18-year old beginner, it was found that in a wide spectrum of paramedical areas no previous educational exposure existed. Nonetheless, a more receptive and interested group would be hard to find; Alaska physicians are to be congratulated for recruiting and teaching these people to function in the medical environment. It was anticipated that the Summer Workshop experience will further enhance their practical skills by providing a basis for future individual study plans. Those who work in administrative capacities were introduced to the necessity for understanding the meaning of medical terms and abbreviations, rather than only typing "what it sounds like." Those in clinical jobs were indoctrinated into recognition and prevention of possible professional liability claims. All were exposed to detailed consideration of ethical values in medicine.

It is hoped that the 1971 Summer Workshop will serve as an impetus for beginning Alaskan classes to prepare Medical Assistants for national certification. Planned evening classes are an important mechanism enabling employed Medical Assistants to pursue a serious course of self-improvement. The seven-section examination offered yearly by the American Association of Medical Assistants and the AMA Council on Medical Education is set up along the same lines as specialty board exams; one who successfully achieves certification is called a "CMA" or Certified Medical Assistant.

Where physicians have contributed to this program by participating in formal teaching efforts at local colleges or technical schools, increasing numbers of medical office and hospital personnel have become candidates for national certification. The benefit to physicians derived from their certified employees' increased efficiency is judged to be considerable. Alaskan physicians who wish to help implement this movement toward increased professionalism in paramedical performance can obtain further information and guidelines from Marion K. Lampman at the Washington/Alaska Regional Medical Program's Anchorage office.

Sincerely yours,

Mrs. Dorothy Fairbanks, CMA
Medical Assistant Program Consultant
Anchorage Community College
(1221 N.E. 103rd St., Seattle)

Information and Referral

Dear Sir,

The Easter Seal Society for Alaska Crippled Children and Adults (ACCA) has expanded its services to establish an Information and Referral Program. ACCA thus becomes a part of The National Easter Seal effort to assist handicapped persons and their families in finding the special services they need.

The Information and Referral Service will try to

reduce barriers between those who need service and those providing health services. It is hoped that individuals will be helped to the proper resource before problems can multiply or the condition becomes irreversible. This service is available to the public as well as physicians and other professionals.

ACCA tries not to duplicate existing programs but to complement them. We plan to maintain formal cooperative working relationships with existing agencies offering Information and Referral. In this way we can work toward comprehensive community health care and maintenance of health care.

Services to clients are Information, Referral and Follow-up. We will maintain accurate data through a continuing survey of community health resources in order that an inquirer can select and use the resources needed. Referral might be providing simple information such as where some agency is located or how to get there, sending a letter of summary, arranging for an appointment or helping the individual to make a contact. We will also contact a client, or agency to which referral has been made, to determine whether the client has received needed services.

This service will benefit the community as a whole by supplying up-to-date information on all health programs in the State. It should also demonstrate unmet needs in services to help in planning future programs. At present, the Information and Referral Service operates one central office in Anchorage. This was housed in the Borough Health Center through the efforts of A. B. Colyar, M.D., Medical Director, with the understanding that at least 50% of the Coordinator's time will be provided to the citizens of the Anchorage area. The program maintains a telephone service from 9 a.m. to 5 p.m. Suicide Prevention and Crisis Service maintains the telephone service after these hours and on week-ends. The secretary and volunteers will give information to clients about resources if the requests are of a routine nature. All other requests for information and referral will be held for call-back by the Coordinator. Collect calls from communities outside the Anchorage area will be accepted if they cannot be handled locally. Correspondence from outlying areas is encouraged.

The Coordinator will assist in the development and implementation of local Chapter Information and Referral Service Programs if desired. In our first year, program expansion is being considered for Fairbanks, Kodiak, Juneau and Sitka — areas which have shown a keen interest in developing this kind of service.

We are currently identifying community resources. Five hundred agencies and organizations have been contacted by questionnaire and their description of services available are being compiled into a loose-leaf Directory. The initial printing will be distributed to all agencies listed as well as Physicians and Clergy. It will be up-dated continuously.

Even though there has been very little publicity to date, calls are being received and requests answered. Most of these requests are for financial assistance for medical and dental care, therapy or equipment. A recent phone call requested assistance in payment for extensive laboratory work-up on a young native patient. The Coordinator was able to inform the Physician's receptionist that the USPH Hospital would honor the prescription of a private physician and would return a report if requested. The laboratory supervisor could arrange an appointment and issue any special instructions by phone. Information on tests performed by the State Health Department Laboratory was also given. A follow-up phone call determined that the parents had returned the child to the hospital for testing.

Our advisory committee is composed of:

Dr. A. B. Colyar, Medical Director, Greater Anchorage Area Borough Health Department.

Continued on page 142



ALASKA MEDICINE



Official Journal of the Alaska State Medical Association
Official Journal of the Alaska Dental Society

1135 Eighth Avenue, Suite 1, Anchorage, Alaska 99501

APPLICATION TO MAIL AT SECOND CLASS POSTAGE RATES IS PENDING AT ANCHORAGE, ALASKA

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About the Cover:

Joe Carter and Florence McIntyre were students at the B.I.A. elementary school in The Eskimo Village of Eek when they produced the work on the cover. Paul and Eloise Forrer, now at Wainwright, taught all grades, all subjects, but still found time to encourage the young artists to extraordinary efforts, some of which will appear in future issues. Eloise, incidentally, is a concert harpist and not uncommonly gives harp concerts in the smaller villages.

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HELEN WHALEY, M.D.

1924-1971

*Ayii, Ayii
There is one thing
and only one thing
To rise
and greet the new day,
To turn your face from the
dark of night
To gaze at the white dawn
arise, arise
ayii, ayii*

She outlived all females of her family for many generations — She loved Medicine as Medicine; people as eternal source of learning and curiosity; nature as source of revitalization; and Bob Whaley beyond everything else — She felt fortunate beyond measure for the many opportunities of all types — and the many loyal friends, despite often purposely annoying — To say more would destroy the great need for being always a private person with Bob —

Helen Whaley, August 16, 1971

This Eskimo poem was her favorite. The above was written two weeks prior to death, with the request that there be no other obituary.



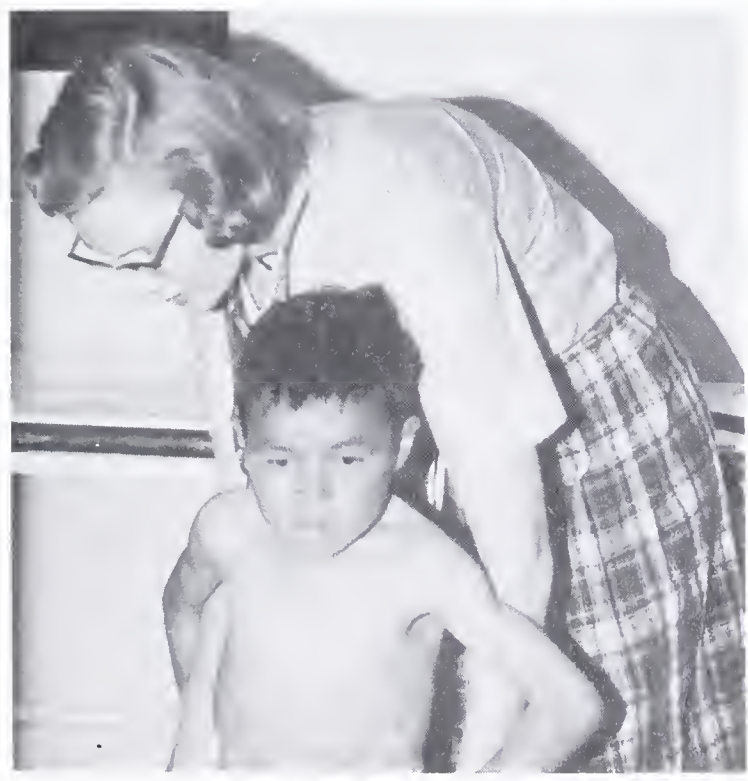
1950



1954
Grayling for Breakfast



1951



PLANNING FOR NATIONAL HEALTH CARE DELIVERY

By Robert Whaley, M.D.

*Chairman, Subcommittee for
National Health Legislation,
Legislative Committee, ASMA*

*Prepared for presentation to Congressional
Delegation — printed in Congressional Record
September 14, 1971.*

The Alaska State Medical Association thanks the members of this meeting for the opportunity to place this statement in the record.

The physicians of Alaska believe that national legislation altering the method of delivery of health care will almost surely be enacted within the next eighteen months by the Congress. We shall not comment in detail on the various bills now proposed or pending, since we believe that final legislation will represent a compromise combining various features of these. The State Medical Association at its annual meeting last June did endorse the AMA's "Medicredit" plan, as the most desirable of current specific proposals, but the association is continuing to study various schemes with interest. We should like to emphasize the following elements as germane to design of such legislation.

I. Much of the often emotional and at times polemical discussion of this problem has implied that the current health care delivery system is sadly deficient and of little value; the term "crisis in health" is commonly used. We feel this to be a gross exaggeration. Although there are clearly significant lacks in the availability of care, particularly in rural and ghetto areas, we believe the majority in Alaska and in the Nation are receiving satisfactory care. We should be certain we are improving the system before radical changes are adopted.

II. The present system is a pluralistic system, appropriate to a free society, encompassing as it does individual practitioners, a great variety of forms of group medicine — both fee-for-service and prepaid, and purely socialistic systems in the government hospital program. (Cost-effectiveness studies of these last systems do not, incidently, engender great optimism for economies, were similar institutions to be widely adopted.)

III. Expansion of health care availability must depend upon the expansion of facilities and personnel. Without this, the stimulation of demands for care can only result in a chaotic competition for available services. The complete

removal of financial barriers to treatment comprises such a strong stimulus. If the ability to pay seems idealistically an unacceptable method of limiting utilization, some other method must be devised as a practical matter, since available funding and facilities have finite limits. Both pre-paid group plans and government hospitals are currently facing this problem.

IV. In the last two decades, the number of physicians has increased about 50%. Although this substantially exceeds the population growth, the number of physicians in actual general patient care has proportionately decreased, comprising now only about two-thirds of all doctors. Motivational factors for this, although partially obscure, can perhaps be altered. Greater use of mechanized systems can improve efficiency at the expense of associated depersonalization, not always satisfying to the sick person. Much greater use may be made of less broadly trained, so-called "paramedical" personnel, and we would strongly encourage this trend, despite some inherent quality loss.

By these and other methods the Doctor supply can be stretched, for it clearly will take some years to significantly expand it. But we must stress that the present system is relatively efficient, particularly for the more common medical problem, in which the Doctor-Patient relationship is not merely a catchword, but the sine-qua-non of rational therapy. As an entrepreneur, the doctor applies care in administration of his business; as one who does piece-work he is stimulated to efficiency; and in the fee-for-service arrangement he has a vested interest in the satisfaction of his client — the patient. You will note none of these considerations apply to some of the proposed plans. And although frequent jokes about the night call and the house call are popular, those of you who have dealt with salaried physicians well understand how it is when you *really* have an eight to five doctor.

In accord with the above then, we should advocate the expansion of medical schools (and perhaps revision but *not* shortening the

curriculum); the encouragement of the utilization of non-M.D.'s in health care, by suitable intensive though narrow training programs in special fields, and by enabling legislation to overcome legal obstacles to their activities; the devising of incentives to relocate doctors to areas of special need, and to encourage the return to patient care of those many now in business, industrial, and research positions. Considerable (50—100%) gain in efficiency will accrue to the credit of he who can eliminate the paperwork involved in medical practice.

V. There is a crisis, if you wish to use the term, in medical care costs, now approaching \$70 billion annually in total expenditure. This is not importantly due to the inefficiency of hospitals, which are in the majority non-profit, and whose labor costs have risen astronomically; it is not importantly due to the avarice of physicians, most of whose hourly wages are not inappropriate to the skills and responsibilities involved, and whose total fees comprise less than one-quarter of total medical costs. Discounting inflation, the two major factors (which must be controlled) are the vastly increased complexity of services, and the loss of control of utilization.

The growth over the last two decades of third party payment for services, together with recent institution of Medicare and Medicaid programs have eliminated natural restraints on expenditure. Deductibles and co-insurance provisions have been of limited effectiveness. Since the physician has traditionally worked primarily for the benefit of his patient (a role we feel proper) he is committed to the provision of all reasonable diagnostic and therapeutic services. The suggestion of some that the expansion of medicare-like programs will result in a solution to the cost problem seems at very least unrealistic. Clearly, if cost to the patient is no longer to serve as a practical limit to services, the limits must be set by administrative officials, medical professionals or otherwise. We feel this is undesirable, but possibly the only solution for those whose medical care must be completely subsidized. Hopefully the size of this group can be minimized.

Another old fashioned tradition in the medical profession is that there is a moral and ethical obligation to use all means at the doctor's disposal in attempt to maintain life or health. But as science has advanced, medical technology has exploded, and with it cost. Today's office call and today's patient-day are not comparable to those of twenty years ago, nor should their cost be. A reasonable projection of present trends would place total medical expenditures in 1980 near \$200

billion, or about 15 percent of the GNP. It seems dubious that the taxpayer will accept this. If he does not, the physicians' duty will then be to provide certain services to the patient only if the expense will be justified by the probable benefit, including both medical and social considerations, notwithstanding the patient's desires. The doctor will thus be an agent of the state rather than of the patient, an uncomfortable role for most of us, and we think for our patients.

VI. In summary, the Alaska State Medical Association feels that the present method of medical care delivery is not so bad as it has been painted in many quarters; that violent change in the system may very well produce more problems than we now have, and may well result in the babies being flushed with the bath water. Of the two major problems visible at present, lack of personnel and facilities is probably more important, and few of the presently proposed plans make adequate solution for this deficit, the correction of which will in any case take some time. We would expressly caution against adoption of any system that would through financing abruptly increase demands for medical service.

The rising cost problem is most importantly one of over-utilization and over-sophistication of services; to suggest that real economies can be achieved by the substitution of bureaucracy for our present system is difficult for most of us to accept, with the great previous projects of the government everywhere at hand for comparison. Under a monopolistic or government-paid plan, economies can indeed be affected, but at the expense of the patient's loss of any control in his management. We would venture to predict that the patient, in this case the taxpayer, under these circumstances would not have great gratitude for those who imposed this system upon them. Many of us feel that the sick patient still needs a doctor, and cannot be well satisfied by a mass production of medical industry.

We would further caution that systems that have evolved over considerable time, though rarely immune to improvement, are very likely to have more virtues than may be recognized, and that elegant systems concocted de novo from the heads of bright young planners are very likely to have more defects than are obvious in the planning state.

Finally, a medical care system deals primarily with human beings, as patients, as doctors, as technicians, and as administrators and planners. A shrewd and realistic estimate of the capacity of this cast for self-interest, pettiness, inspiration and ingenuity may optimize the design.

PRESIDENT'S PAGE

By J. Ray Langdon, M.D.

Since June your President has been fairly active in community affairs. There has been mixed reaction to some of my statements, but it should be noted that the majority of the reaction has been favorable, even on the marihuana issue. This should point up the fact that physicians still are looked upon as leaders and will be so treated if they show an active interest in the community and society about them. Others of us, of course, have done and are doing the same, but we still need more representation from our multi-talented membership.

In viewing our Alaskan scene, we may still play ostrich and assume we live in the best of all possible worlds as some of our newspaper editors imply at times. In Alaska it is assumed that we do not have nor will we have the problems of Attica or the Cuyahoga River and I suppose this is the same silly assumption the early migrants to California labored under — and they now have San Quentin and the pollution of San Francisco Bay. I realize that ecology, environment, conservation and resource development are all highly emotionally charged words here, about in the same league as “facist imperialist pigs” and “dirty, long-haired hippies”, but it might be hoped that we can keep our poise enough to help keep the strife to a minimum and arrange acceptable solutions. Several of us participated in Anchorage's Operation Breakthrough a couple of years ago and even though much has not been implemented, a number of worthwhile studies and recommendations for action were made particularly regarding community development such as housing, mass transportation, air and water pollution, and economic development. There is still much resistance to some of these items from conservative groups in the population despite what seem like obvious needs to most of us.

I still hear some of our members stating that this or that social issue is not part of medical society concern although we recognize that they do play a role in the total health or illness of our actual and potential patients. If we complain about bumbling bureaucracy and the difficulties it causes us, how much more malevolent it must be to those

who may be recipients of its largesse. This does not refer exclusively to the “poor” people either, as mass transportation, air and water pollution, drug abuse, and crime affect most segments of the population.

For the past five or six years the nation has had repeated episodes of violence in the form of race riots, mass protests against the war, and recently the prison disturbances in California and New York. It is noted that the Nixon Administration has placed more emphasis on prison reform and corrections than any previous administration, though as usual we have waited until the problem has grown so gigantic as to be essentially insoluble. Prisons exist as a result of social and psychological ills, but they have become social problems in themselves, and spawn more through the present decrepit system.

What has this to be with Alaska? On almost every topic, from city planning to hospitals to state and local government, it is said that Alaska has (or had) a golden opportunity to profit from older communities' mistakes and do it right this time. Thus we have various degrees of mess in local governments, the state government has bumbled along gradually accumulating a large (per capita) bureaucracy and an unresponsiveness to the governed that would do justice to much larger states. So far our prison system has been largely on Federal contract, but we are bit by bit developing a “correctional” system — McLaughlin Youth Center, the Palmer adult camp, the new Juneau facility, and the proposed Southcentral Regional Corrections Institution near Anchorage. It seems incumbent on us not to let these new facilities become running sores like nearly all states and even the Federal government have. We must try to influence the system to provide treatment and training rather than brutality and punishment.

As the Division of Corrections is part of the Department of Health and Social Services, we should include it regularly in our concerns with that Department, get to know the officials, the policies, and the programs. We must not let one of these institutions become Attica North.

ON THE EDITORIAL POLICIES OF ALASKA MEDICINE

By A. von Hippel, M.D.

Over the past four years *Alaska Medicine* and its editor have received both praise and condemnation. We have been threatened with possible lawsuit, grievances have been filed, and barely intelligible contributors have sworn to expose the editor as the arch-villain that he truly is. We have been labeled both socialist and fascist. Yet other letters have been received that alleged withdrawal symptoms when an issue was not sent on time. For all this we are grateful. At least *Alaska Medicine* is being read.

One recurrent complaint has it that *Alaska Medicine* has turned pseudo-scientific; that it is a medical sham. Rather than resort to probably true but counter-productive responses such as "It takes one to know one", we might review current editorial policies and practice.

The Facts: *Alaska Medicine* is published quarterly by the Alaska State Medical Association (ASMA). The Editorial Board of *Alaska Medicine* is the Council of the ASMA. The Council is empowered by ASMA by-laws to appoint or disappoint the Editor-in-Chief, as well as set broad guidelines for the journal. Pending the impeachment, retirement, or demise of the editor, his decision on usage of any material submitted, from whatever source, is final.

The Finances: *Alaska Medicine* has made a few dollars or come out even on the last few issues. Prior to this it was an intermittent money-loser. A debt of many thousand dollars to ASMA is still outstanding. Our charges of \$6.00 single or \$5.00 for group subscriptions do not cover the cost of printing and mailing each issue. Only our advertisers make it possible to continue. Currently we distribute about 1,200 copies per issue, about half of these go outside of Alaska.

Alaska Medicine has no paid staff, although we impose mightily upon the ASMA office in Anchorage for secretarial as well as research support. Our executive secretary, Mr. Bob Ogden, has recently taken on the additional burden of the Muktuk medical gossip column. This was originally and for many years a special project of Dr. Helen Whaley.

The average issue of *Alaska Medicine* takes about 80 hours of writing, rewriting, letters, proofing, reproofing and layout activities by the editor. Many of the associate editors, as well as others not listed, spend long hours reviewing contributions for possible inclusion, writing introductions, or giving reasons for rejections. It

should be noted that almost all articles are reviewed by at least two qualified persons, including those rejected. It is always unpleasant to reject an article. Major changes are frequently suggested, or made editorially with permission, to bring the prose more in line with what is desired. Most authors are or were personal friends of the editors. Many articles only get written after much urging, yet our rejection rate approaches 50% of all articles submitted. Possibly this has helped assure the editor of continued spare time in his referral practice. If a good hobby is one which appears to make time for itself, being editor of *Alaska Medicine* must be a good hobby.

Many technical journals such as *Science* request that authors of articles submitted from solvent organizations provide a contribution to offset publication costs of their work. For several years the Alaska Dental Association has carried this responsibility for their section of *Alaska Medicine* without complaint. The editorial burden for articles on Dental topics has been ably born by Dr. R. A. Smithson during this time.

More recently we have also asked contributors representing state and federal health services to support page costs. No really good article has been refused because such financial backing was not forthcoming. However, the length of each issue is limited by the need to break even financially, and some pressure has thus been applied for a routine page cost commitment. Friction and misunderstanding have resulted and certain officials in our greater bureaucracies have alleged that they were charged advertising rates for their "scientific" contributions. Advertising rates, incidentally run up to \$225.00 per page compared to an actual page cost of about \$40.00.

We might add parenthetically that some of the material from such sources that has seemed unsuitable for *Alaska Medicine* by reason of lack of interest or relevance would be reconsidered at the higher advertising rates. We have lost quite a number of ads by a relatively adamant refusal to sprinkle them among the articles. This is also an editorial decision. Incidentally one page of *Alaska Medicine* print is equivalent to about five double-spaced typewritten pages.

Scientific? As for the content of our articles, well, the daily practice of medicine is not all that scientific to start with. In any case, it is highly unlikely that a major medical advance will first see daylight within these pages. Should we then reprint

important material from other easily accessible sources, or possibly accept papers reporting more questionable advances or studies?

To maintain readability, to provide opportunity for participation of our first-class Alaskan medical talent, and to avoid loss of our Alaskan character, we routinely refuse to reprint material submitted or published elsewhere. Only original work is accepted, and we give some preference to contributors from our own medical association. Except for special issues, such as the recent one on Alaskan health facilities, edited so effectively by Dr. Paul Eneboe, articles are not

usually held over for the next issue. Thus, a delay of less than three, or occasionally up to six months may be encountered.

We attempt to publish current articles of medical or general Alaskan significance. Your literate and interesting contribution is hereby solicited, whoever and wherever you are. Do not be alarmed by a delay in acknowledgement or acceptance, as little is accomplished between our quarterly flurries of activity. Quite often we publish controversial articles. In general, we are happy to give equal time to literate and interesting rebuttals. Many complain, but few make the effort.

ENCROACHMENT OF THE MONTH

Through a Cabinet order-in-council, the British Columbia Health Minister can now order hospital boards to accept or reject individual physicians for practice in any hospital. This control over the physician's place of practice was allegedly necessitated by "the unbalanced distribution of physicians". The British Columbia government also now limits the number of x-rays and lab tests a physician may perform in his office or private lab.

* From Sept. 1971, *Results* published by WARMP, 500 U. District Bldg., Seattle.

TOO FEW DOCTORS?

"Millions of Americans would benefit more from changing their dietary habits, losing weight, exercising, stopping cigarette smoking and cutting down or ending their consumption of alcohol and other drugs than from having more physicians and more hospitals available to treat them after their bad habits laid them low."

— Harry Schwartz, *New York Times*

MISUNDERSTANDING OF THE MONTH

A highly agitated young female came in recently for another opinion on her mildly symptomatic hiatus hernia. She stated that her physician had given her only four years to live, and that surgery would not help her condition!

His actual statement was "You can live with these symptoms for years without requiring surgery."

A CHEST SURGEON COMES TO ALASKA

By F.J. PHILLIPS, M.D., FACS

When I came to Alaska in 1950 as chest surgeon for the Seward Sanatorium, the heart had not yet become a South African organ. The challenge in Alaska was still pulmonary tuberculosis. Miracle drugs were not generally available. Streptomycin was still a youngster in the war against the mycobacterium tuberculosis.

The treatment of tuberculosis was mainly a matter of rest. Rest for the entire body in a Sanatorium and rest for the lungs by various forms of collapse therapy. The once popular induced pneumothorax had been partially replaced by the pneumoperitoneum which was used to elevate the diaphragms and put the lung to rest. This was not very popular across the nation because many thought it dangerous to stick needles through the abdominal wall into the peritoneal cavity, on account of the risk of piercing some organ such as the spleen and causing internal bleeding.

In the older pages of surgical history, men like Sauerbrück, Willy Meyer, Alexander, Coryllos and O'Brien had devised a rib removing operation called a thoracoplasty. Early in the century this operation was put into use with encouraging results. A new treatment for a world-wide scourge had come into being.

This was the era in which I studied medicine and surgery. I was the first Fellow in Thoracic Surgery under William E. Adams at the University of Chicago. I became well grounded in surgical techniques and basic knowledge there. After a year, I went on to Detroit. Here I was further disciplined by E. A. O'Brien and William Tuttle at the Wayne County Public Health Organization in the technical niceties of thoracoplasty and occasional intrathoracic operations. But as my skill developed and my confidence grew my career was to change temporarily.

Hitler had started a war in Europe. I had been a reserve officer for thirteen years, most of the time in the Infantry. As war clouds gathered I transferred my commission to the Medical Corps. The calls to active duty came rapidly for all reserve officers. I was among them.

May 1941 found me packing up to move to Camp Croft at Spartanburg, South Carolina. In my last week as civilian I did 17 major and 27 minor chest operations. Over the next four years I went from ward officer to 2nd in command of a 700 bed station hospital, to chief of pathology, chief of medical records, to chief of medicine, but *never* to chief of surgery. My only chest operations were minor procedures. Two esophagosopic aspirations

for foreign bodies and one herniorrhaphy on the Island of Atka in the Aleutian chain. There I was in command of the 50 bed station hospital and Post Surgeon for Atka. Oh, yes, I put the first aid dressing on a Colonel's thigh in the Hurtgen Forest in Germany.

Finally I became Division Surgeon for the 28th Division. This organization had started out as the Pennsylvania National Guard Division back in World War I. A Division averaged about 15,000 men in those days. When I became the Surgeon we had gone through 45,000 replacements. If there was any place in the European Theater of War that was real tough we were sent there. We finally got the real "sacrificial lamb" position and were spread thinly along the Our River between Luxembourg and Germany to become all but annihilated by the German Attack in that sector. It was known to all then as the Battle of the Bulge. Since then, known mostly to historians and relatives of the sacrificed 28th Division fighting men. But it did end World War II.

The Division was replenished with green soldiers and given an easy assignment, occupying the Saar Valley. We accepted displaced Nationals from nearly every Western and Central European Country. Finally we had 73,000 displaced persons under a sort of riddled umbrella of control. I had had no formal training in Public Health up to that time. I was not sent out to a special school. It seemed best to send the Division Surgeon, who had started with the organization and was miraculously still alive, back to Pennsylvania with the questionable honor of being one of the few originals of the organization still living. This left a vacancy at the top.

A great honor was given me. I became the Division Surgeon with 73,000 Public Health non-English-Speaking problems. Everything was needed. Medical supplies for French and German Hospitals, food, sanitation. Not only did we supply latrines, but we had to teach the nationals how to use them. There were no ecologists in those days. Public Health knowledge came to me fast and arduously.

With the Hiroshima Bomb, the war was over. I had been in five Theaters of war from the Arctic to the Rhine. My military rank had gone from 1st Lieutenant to Lieutenant Colonel. However, I had done no surgery in over four years. Chest surgery was a new and progressive field. Its scope and techniques were changing rapidly. Intratracheal anesthesia was just beginning. The experience of

surgeons at the Front in battle wounds had taught them much about chest surgery. I was only four years behind in time, but pretty lost in understanding the new techniques. In fact, I was really just a "chest wall" surgeon.

It was with real gratitude and relief that I accepted an appointment as instructor in surgery with my former Chief, Dr. W. E. Adams at the University of Chicago Clinics. It could be debated who got the instruction, the medical students and interns or me. My salary was \$450.00 a month. This was comparable to my pay as Division Surgeon. My wife and daughter lived with her invalid mother and niece in the Upper Peninsula of Michigan. I was lucky to get a nearby hotel room to sleep in, let alone find an apartment for my family just after the war. Two times a month I commuted by train to Iron Mountain, Michigan for a week-end visit with them. This was nearly an all night trip.

After six months I was appointed Superintendent and surgeon at the Morgan Heights Sanatorium at Marquette, Michigan. Using the six months at the University of Chicago Clinics I was able to complete case requirements for my Fellowship in the American College of Surgeons. While at Morgan Heights I completed the paper work and using film strips, projected records of my cases. I was accepted as a fellow (FACS). No anesthetist was available, so it was necessary to import an Anesthesiologist from Chicago on week-ends to help me. We felt real fortunate to be able to get one case done.

The cases had active tuberculosis so we were not permitted to do them in the downtown general hospital. There were many disadvantages to operating at the Sanatorium. We lacked adequate equipment and the personnel were not used to chest surgery . . . Not too many cases were eligible or physically able to tolerate the type of surgery they really needed. After a year there I still wanted to do just chest surgery. Although the Army Medical Corps had "over-trained" me in administration I was not enchanted with it.

My next move was to the V.A. Hospital at Temple, Texas. It had been the McClosky Army General Hospital during the war years. There were only one hundred in-patients with tuberculosis, so the surgery load was light. Consequently, the V.A. sent me to their hospital at Legion, Texas, for a week or ten days at a time, to do the chest surgery there. I also learned to fly on my G.I. Bill and did a fair amount of flying in East Texas and West Louisiana. I was never cut out to be a pilot and gave it up after 87 hours, a license and no accidents. Time passed slowly for me in those days. Inactivity was bad for me. I was difficult and dictatorial. I played golf, tennis, swam, made a garden and disagreed with nearly everyone in the Veterans Hospital. Finally, I wrote my own resignation. I

felt relieved and I am sure that the Administration shared the same emotional satisfaction at my going willingly. I had been there a year and two months and was still interested in doing only chest surgery.

We moved to Shreveport, Louisiana. Here I became associated with the Gowan Sanatorium as their Thoracic Surgeon. I did only chest surgery. It seemed then like all types: Thoracoplasties, decortications, segmental resections, lobectomies and pneumonectomies. While there I was honored with a Founder Membership in the newly formed Board of Thoracic Surgery. I was doing well with my surgery and was accepted in the community. I worked in six small hospitals in Shreveport. Once a month I drove 117 miles to Monroe and did surgery and consultations there all day. Patients came to me through local doctor referrals, from East Texas, North Louisiana, Mississippi and Arkansas.

It was not my fame that brought them. Surgical treatment of the chest was being heard of more widely. There were very few chest surgeons. All of us were busy. This was one of my best periods, but also one of the most arduous. There were no interns. My surgery nurse and I did all the surgical care of the patients in the six local hospitals. I was doing something with patients from 8 in the morning until after midnight. Often I slept in my car outside the hospital so that the special nurse could find me if anything went wrong with a recently operated patient. I would move from hospital to hospital if more than one had a patient subject to bad postoperative complications. My war toxicity was diminishing and I was beginning to feel the wear and tear of 20 to 22 hours days. This was to last only a year. Then, as the itinerant preachers used to say "The call came".

Dr. C. Earl Albrecht, then Commissioner of Health of the Territory of Alaska, needed a chest surgeon at the Seward Sanatorium. I drove from Shreveport to Anchorage with my personal instruments and a few other necessities. The "Spell of the Yukon" had not been broken. I had not forgotten Alaska. When this opportunity came I was ready.

I arrived in Anchorage at 4:30 A.M. on May 17, 1950. After a bath in the help's quarter in the basement of the Anchorage Hotel and a light breakfast, I went to the Anchorage Office of the Territorial Health Department. There I was greeted by Dr. Robert L. Smith, then Assistant Commissioner. I met the folks in the office and with the help of Mildred Augustine, his secretary, I got a room at the Westward Hotel. Plans were formulated for us to fly down on Monday. This being Thursday I had ample time to get my car to the Alaska Railroad freight depot and ready for shipment to Seward. I was glad to be back in Alaska. We flew Christianson Airlines to Seward

Monday afternoon, where we were met by Dr. Joe Shelton. He really welcomed me to Seward.

A short tour of the Seward Sanatorium showed that this would really be a challenge. There was no surgery nurse. The hospital was without an administrator. There was no anesthetist experienced in intrathoracic surgery. The Womans Division of Christian Service of the Methodist Church operated the Hospital. The Territorial Health Department furnished the doctors. The institution operated on a per diem basis.

It had started about four years before as a rehabilitated Army Cantonment type hospital, originally operating under the name of "The Home in the Woods". When I arrived on May 20, 1950, I was not sure that the name should have been changed. The ups and downs of this institution could easily make another story. However, I had signed a contract and I could stay.

I started to get acquainted and study the problems. Dr. Karola Reitlinger was there, trying to hold the place together. She was very kind to me and tried to see that I was well received by the patients. About June 4 I received a call from Dr. Smith in Anchorage telling me that I was now the Medical Director as well as the surgeon. My original agreement with the Health Department did not include this. Why make an issue of the added responsibility, there was no added salary. Anyway, with no surgery nurse and no anesthetist, and with blood for transfusions having to be shipped in from Seattle, about all I could do was be the Medical Director.

I had a few problems too. I could not tell one Eskimo from another. It took a long time for me to get to know the individual patients. I was not accepted right away by them. When I came to their bedsides they would sometimes read with the book upside down. I realized finally that it made no difference. They could not read anyhow.

About six weeks after my arrival the surgery nurse returned from leave and Mr. Paul Nelson, the administrator, came back from Chicago where he had been to a special school for Hospital Administrators. During this time I had given a few refills of air to one pneumothorax patient. Some patients had been started on pneumoperitoneum. Several had been bronchoscoped.

I had helped Dr. Shelton do surgery at the downtown Seward General Hospital. He had taken me on a few air trips to see the fabulous scenery in the mountains near Seward. I had been hooligan fishing and even caught one silver salmon in Resurrection Bay. An interesting though not very exciting time for a dedicated thoracic surgeon. I had learned to wait in the Army. Anyway my family had arrived and things in general were better.

Finally Dr. Shelton and I decided to try to do a thoracoplasty, and in August, 1950 we did it.

Miss Murrel, the nurse anesthetist from Seward General Hospital put the patient to sleep with what was then considered a very modern new Heidbrink gas machine. The patient had ether through the machine. Two units of blood were there from Seattle. The operation went well. The ribs were removed. The patient survived. Everyone at the Sanatorium was relieved. The staff agreed that I was really a good chest surgeon. The anesthetist claimed that she had gone through the operation with great fear. She was not really very secure in her work. I had worked with varying types of anesthetists while in Louisiana, so I was not too concerned. In the next several weeks we had one other anesthetist who was equally fearful.

One day a young woman came to see me about her chest. After getting the Medical side of the meeting over with, I learned that she was a registered nurse. No only that, but she had given anesthesia for a group of nose and throat doctors in Seattle before coming to Alaska. She was the wife of a local longshoreman and likely to stay in Seward for some time. She was persuaded to try her hand with me. It was agreed that I would teach her to pass the intratracheal tube and would always be right there. She was alert and learned rapidly. In the beginning I would pass the tube and get the patient "leveled off" for her and things would then go well. Such luxury! I had my very own anesthetist.

The overall operation of the Sanatorium went well until the next fall. Then on October 4, 1951, Dr. Shelton left Seward to study to become an eye specialist. The day he left there were 143 patients in the Sanatorium. That afternoon I saw 35 patients in his office down in Seward. Not only my assistant, but my best friend in Seward was gone. Adjustments had to be made. I had to adjust to making rounds at the downtown hospital at 6 A.M. so that I could have breakfast with my family and be ready to go to work at the Sanatorium at 8 A.M. Dr. Richard Sellers was in Seward, but he was not interested in chest surgery.

Fortunately a very capable young woman who had now become the Director of Nurses. She reluctantly became my first assistant. The original surgery nurse had left Alaska. I learned that one of the nurses working floor duty had had experience as a surgical nurse, so she was brought to the operating room. She was very capable and alert. The operating room orderly was a diligent ex-medic, so he became the circulating nurse. We were in business again.

From time to time I would have various doctors as assistants and for training. Finally, an arrangement was made with the University of Chicago Medical School to import senior or junior medical students. They came up and stayed 6 months. This arrangement worked out very well. Dr. Joseph Deisher had joined me in the downtown

office, so that some of the load was eased. Occasionally he assisted with the surgery.

The policy of getting blood from Seattle was pretty awkward and undependable. We were able to get a very capable laboratory technician about that time. She was Canadian trained and did excellent blood work. By indicating our need for blood and cultivating the people around Seward, it became possible to get the blood locally. Frequently I would strike out a few days before we were to do big surgery and visit the Kenai Lumber Mill and the Longshoreman's hall to persuade them to contribute a unit of blood. We did not have a blood bank, so we had to match them up with the particular patient. However, it worked very well. The donor got a free blood test and a card with his blood type on it.

On one occasion a neighbor brought his child in with severe post-tonsillectomy bleeding. It happened that her father and she were the same type so at midnight we crossmatched them and gave her an appropriate amount of her father's blood. He was proud to do it, and she lived.

Unusual experiences were numerous. One segmental resection for suppurative disease of the right lower lobe revealed a tooth in the bronchus. The patient had had much dental work and had no idea she had aspirated the tooth. One 8 or 9 year old boy had an ordinary pin in the left lower lobe out near the chest wall. We took xrays and with the pre-operative aid of the fluoroscope, localized the pin and under anesthesia removed it in a few minutes through a two inch intercostal incision.

On one occasion we were about half through an intrathoracic operation when the power failed. I had insisted on maintaining an army portable floor unit with a regular six volt storage battery in it. This was now moved into the field and the operation completed.

Two dental units had been set up ready for use in the main building. We had 150 patients, nearly all of whom needed dental care almost as an emergency. No dentist was available. We did have Dr. Hittson available do dental work during a couple of winters. He was really working for the Territorial Health Department on the Health Boats that followed the shoreline dispensing "health" during the summer.

When he left we were able to get Dr. Lee McKinley of Anchorage to come down on Saturdays and do dental work for us. He flew his own plane down and did a lot of work. If he needed a general anesthesia I would give it for him. Since I had had maxillo-facial surgery school in the army, I soon learned to do extractions and minor fillings. We finally worked out a system. I would do the extractions. Then, if more extensive work was needed, like a bridge or a plate I would bring them to Anchorage and Dr. McKinley would

do the special work. This did not make me very popular in dental circles in Alaska.

All was going well until Seward was hit by a poliomyelitis epidemic. My nurse anesthetist, Mrs. Claire Rose, developed bulbar polio. She recovered in about two years, but gave no more anesthesia. More adjustments had to be made. Our only recourse for many months was to borrow an anesthesiologist from Elmendorf Hospital and do our work on weekends. My staff was not happy with this, but they were well motivated and did it. One weekend we did 9 major chest procedures from Friday morning to Sunday noon. We had stored up 24 pint units of blood for this time in refrigerators all over the Sanatorium.

In 1952 I started doing a simple type of surgical lung collapse developed by Dr. W. E. Adams, then consultant at Chicago Municipal Tuberculosis Hospital. It was a localized collapse of the lung inside the chest accomplished by inserting little warm paraffin balls through a small incision between the ribs. It was called a subcostal extrafascial pack and was a boon in collapse therapy for us. No blood transfusions were needed. The operation did not mutilate the chest wall. After Mrs. Rose was incapacitated, we started doing them under local block and regional anesthesia. About 1956 we were fortunate in getting Walter Schultz, R.N., a well trained nurse anesthetist, to help us. Although he remained until I moved to Anchorage in 1957, we still did the Adams operation under local as it was easier on the patients.

The American Medical Association has preached for many years that the doctor should take part in community affairs. Since my major endeavor in the medical field had to do with tuberculosis, it was not easy to avoid civic involvement. Tuberculosis was not only a personal problem of disease to the patient but a community problem. It was contagious. The indigent were especially likely to be afflicted. There was the age old stigma with those infected being shunned socially. Employers were very reluctant to hire any one who had ever had tuberculosis of the lungs. Obviously these people had many problems. Their disease was not the only thing to overcome.

I had been hired to do chest surgery, but my answer to these problems was to retrain the patients for a less vigorous kind of work. We had problems with this venture. The average educational level of the native patients was a desultory 3rd grade. This meant that we would not retrain them, but *train* them. Almost any kind of acceptable work required more than a 3rd grade education. We had only one teacher in the Sanatorium. She was on loan from the Territorial Department of Education. For 150 poorly schooled students who were more or less confined to bed we needed more teachers.

A few months after my arrival I persuaded Mrs. Ray James, a civic minded business woman, to help me organize a Sanatorium Auxiliary. She knew the women in town and what they could do. Soon we had an organization of women who took turns coming to the place certain afternoons and offered their help to the patients for errands, shopping and so on. This gave the patients contact with the "outside world". More important, the outside world found that these were just people, and that the TB germ was not jet-propelled. From this volunteer service grew our rehabilitation effort. The volunteers had at last found a place where they were needed.

It became contagious. Others asked to help. Within a year we had many different arts and skills being brought to the patients. Art teachers appeared. In fact many talented people in Seward seemed to come from oblivion. They wanted to be needed. We took care of their wants. Beginning courses in art, French, bookkeeping, dress making, skin sewing, shoe repairing and cooking were started. Initially, bed side teaching was the vogue. As the patients improved we had classroom courses for them.

Our project did so well that it was noticed by the Office of Vocational Rehabilitation. They offered to help in a material way. With funds from this agency, we were able to rehabilitate a half-block long old Army warehouse, and convert it into shops and quarters. We had a kitchen and a dining room for rehabilitees. As patients were discharged they moved to the Rehabilitation Center. For an example of shop activities, Bucki Nelson, who before had been a volunteer teacher, had her own dressmaking shop and taught dressmaking to those interested. Her girls made the formal gowns for the Rainbow Girls installation ceremony one year. One of the Caucasian patients had once been a shoe maker. He organized and operated a shoe shop. Our one vocational counsellor was a young woman who had been a teacher at Mount Edgecumbe Hospital at Sitka. She was a real help in getting patients motivated for training because of her great enthusiasm and inspiration. She is now married, has grown children of her own, and is writing books on Alaska.

The Rehabilitation Center prospered. Early in its operation I went to New York University and took additional work in physical restoration practices under Dr. Howard Rusk, already known world-wide for his work in Rehabilitation at the Institute of Physical Medicine. We tried to keep abreast of the times if not stay in the lead. We had both successes and failures. One Eskimo who came to the Sanatorium with less than eighth grade schooling and both lungs badly infected with tuberculosis learned bookkeeping. He is still the bookkeeper for the Wesleyan Hospital for Chronic

Disease. Many returned to their villages as leaders because of their new skills and knowledge.

We had many failures too, often because of sociological and ethnic problems. It takes more than a few months to re-educate a people to a new way of life. Under the supervision and help of the Office of Vocational Rehabilitation we were able to compensate the teachers of special skills as well as ordinary skills. The trainees also, were given a stipend for maintenance. Chest Surgery? Well, not exactly, but it was part of getting the patient well and back to work.

I was not the only doctor to come to Alaska to do chest surgery, nor the first. Dr. Robert Vallee, a native of South America, had done the first chest surgery in Seward as early as 1947. He was there for a year as Thoracic Surgeon and Medical Director, then left. A few months after he had gone, Dr. Lawrence Lowell from Portland came. He was also the Thoracic Surgeon and Medical Director. He stayed a year and went back to Portland. It was rumored that his wife did not like Seward. On his departure I was found and brought to Seward. That was June 4, 1950.

Dr. Fred Coddington came to Mount Edgecumbe sometime in 1949. He stayed about three years. They were then without a regular chest surgeon until 1959 when Dr. Joseph F. Wilson came up from Tacoma Indian Hospital. The Alaska Native Health Service Hospital in Anchorage opened in 1952. Dr. Robert Moles came there in 1954, but found no chest surgery instruments. When I learned of this I went through our instruments at the Seward Sanatorium and loaned him half of our chest instruments. We had plenty. The equipment from 4 or 5 station hospitals had been dumped in our warehouse at the close of the war. In those days I was consultant to the Alaska Native Hospital and scrubbed with them occasionally, as well as advising on treatment problems. Then Dr. Thomas West came in 1956. I still consulted and occasionally scrubbed with him. Dr. Fred Hillman was there from 1958 to 1961 and did some of the chest surgery. In fact, he did a great number of cases.

For several years the Elmendorf U.S.A.F. Hospital sent all chest surgical cases to one of their hospitals in the South 48. Then one group of surgeons got interested and received permission to do them there. I became a consultant there also and worked with them on many cases.

Those were the busy years. I had 150 patients at the Seward Sanatorium and ran the rehabilitation center and a private practice. It was necessary to travel a great deal. With the advent of miracle drugs in 1952, the surgical load began to diminish. The Indian Bureau had also been taken over by the U.S.P.H.S. and they were able to handle the load of Native patients. Seward

Sanatorium was becoming unnecessary. Chest surgery was becoming passe for tuberculosis of the lungs. My family was growing up. They needed better educational advantages. We moved to Anchorage in June 1957.

An era was passing and I was now in the wrong period as a chest surgeon. The new drugs were rapidly diminishing the need for surgery for tuberculosis of the lungs. That was my stronghold. Even though I had done many other things in Alaska, my real surgical contribution had been in tuberculosis. I still did work at Elmendorf Hospital, but less and less. I went back to gardening and 'haunting' the Providence Hospital Emergency room.

I became a Board Member of the Heart Association and one year I was the Chairman and conducted the drive. Then there was the Alaska Crippled Childrens' Association. I was a Board Member in it. Vocational Rehabilitation Consultant was another. Some one decided I should be President of the Board of Goodwill Industries. It failed. I was Medical Director of the Alaska Western Life Insurance Company for 6 years. It failed, but after I left. For 6 years I was Medical Advisor to the Alaska Methodist University. When the University officially opened, I was delegated by the University of Chicago to represent it at the ceremonies. I continued to work in the Chest Clinic at the Health Center. I had been instrumental in starting it in 1952. This was a chest clinic for followups on arrested TB cases. Later it became a dispensing clinic for TB patients who were on the miracle drugs.

In 1959 I was asked to become the Medical Director of the Anchorage Health District for 3 months until someone else could be found. In

1962 I gave it up to Dr. David R. L. Duncan and became the South Central Regional Health Officer as well as Chief of the Section on Tuberculosis Control for the State. Some of these were not very formal appointments, but there was no one to fill the positions and the State Health Officer saw to it that I got paid something. In 1960 I was appointed Anchorage Independent School Medical Advisor. Together with other members of the Administrative staff, I helped organize the School nursing program that still exists. When the borough became a reality that position ended. The Greater Anchorage Area Borough Health Officer automatically became the school health officer as well.

I was replaced as South Central Regional Health Officer by a full time Public Health Physician. Dr. Robert I. Fraser, the present incumbent as Chief of Tuberculosis Control, replaced me on a full time basis in the spring of 1964. I continued to be a consultant in the Section of Tuberculosis Control for another year. Since that time I have been doing private practice and nursing two painful arthritic hip joints. With the coming of well trained young chest surgeons it no longer seemed necessary for me to do that hard work.

For a while I assisted at surgery. This I always enjoyed very much. In all sincerity I never really liked to do surgery and always felt content to assist some one else, particularly if he was a good surgeon. Surgery had always seemed like a disagreeable part of helping the patient get well. It was extremely gratifying to me personally when scientists found chemicals that would arrest tuberculosis.





AURORA DENTATUS

Guest Editors
Dr. Thomas S. Redmond
Dr. James K. Harrower

CURRENT EVENTS

Congratulations and best wishes to our newly elected officers of the Alaska Dental Society. May they have a successful and productive term in office.

President, Dr. George Fraley, Juneau; President Elect, Dr. Craig S. Kauffman, Anchorage; Secretary, Dr. William Marley, Homer; Treasurer, Dr. Richard E. Williams, Anchorage; Past President and Executive Secretary for 1971-1972, Dr. Geraldine T. Morrow, Anchorage.

The South Central District Dental Society, at a recent meeting, admitted to membership Drs. Donald G. Chiles and George Zirkle. Dr. Chiles comes to us from a residency in oral surgery at Veterans Administration Hospital, Houston, Texas and is now associated with Dr. David Beal at the new Providence Professional Building. Dr. Zirkle is associated with Dr. Michael Maxwell on East DeBarr.

Other new additions to the Anchorage Scene; Dr. Richard Day has a new associate in his orthodontic practice. He is Dr. Ronald I. Glaeser, recent graduate of Howard University's orthodontic program. Dr. Glaeser formerly practiced in Hagerstown, Maryland. (Dr. Day was also recently appointed South Central District Dental Society Representative to the Greater Anchorage Area Borough Health Department Task Force on Drug Abuse.)

Dr. Bob Bliss has a new associate also. He is Dr. William Fell, recently released from active duty with the United States Air Force at Elmendorf Air Force Base and a graduate of University of Southern California Dental School.

Dr. Gene Morton formerly of Greeley Colorado is currently associated with Drs. Driskell, Rick and Harrower.

Welcome gentlemen. May you have a long and successful practice in Anchorage.



A Hearty "thank you" to Tom Lewis, Assistant Dean of the University of Washington Dental School. Their Continuing Dental Education Program brought two fine Post-graduate courses to Anchorage at the Westward Hotel, October 1 and 2.

A course in "Recognition of Muscosal Lesions" for the Hygienists and another on " N_2O-0_2 Analgesia" for the dentists and assistants were well attended and received.

Tom was the guest of Dr. Luther Paine for lunch at Alyeska Ski Resort and remarked how fortunate we in Anchorage are to have such a fine ski and lodge facility. "Beats anything we have in the Washington-Oregon area for setting, appearance, and convenience", he said.

Thanks Tom! You and your clinicians are always welcome in Alaska.

OF CROCODILES AND DENTISTS

By J. Harrower, D.M.D.

Much to the envy of our various colleagues, Dr. J. A. Oney, Anchorage dentist, and myself recently took part in a scientific expedition sponsored jointly by the Australian Government and the University of Sidney, Australia's leading university. We departed Anchorage on May 7, 1971 and returned the first of August, after spending over two months in Australia's outback.

Our group launched a program that is scheduled to continue for at least ten years, researching the great salt water crocodile. Most experts feel that "Crocodylis Parosis" is facing possible extinction, at least in the waters of Malaysia, New Guinea and coastal Australia. Our conclusions only reinforced this theory as we found them to be very scarce indeed.

This opportunity came about through our involvement with a polar bear research project off the northern coast of Alaska in the spring of 1968. One of the principal polar bear investigators, Professor Harry Messel of the University of Sydney, also head of the crocodile research project, graciously asked us to join him. Tony, myself and Basil Bradbury, a photographer from California, were the only Americans to go. The others were all Australians, some only with us temporarily as local experts and guides. A more colorful group of characters could not be imagined.

The prime objectives of this first year were to determine the best areas for capturing crocodiles, to perfect methods of capturing them alive, and to work out proper drug dosages for immobilizing them long enough to make the observations essential to the program. Eventually a radio transmitter will be placed on their backs to monitor future movements and activities.

The crocodile is a fascinating animal, especially from the physiological standpoint. They are a cold blooded reptile with the typical reptilian three chambered heart. They grow and mature very slowly — not becoming sexually mature until they reach their mid twenties and attain tremendous ages, possibly two centuries or more. The largest ever recorded for Australia was killed in Northern Queensland and measured 31 feet in length.

We captured a total of sixteen crocodiles ranging from several feet up to 12 feet long. A variety of methods were used for the capture. The most successful consisted of blocking a stream or water hole completely with 12" mesh fish net, then letting the crocodile get himself tangled in the net. We also used snares and harpoons. Most of the trapping and all of the snaring and harpooning was done at night, usually with spot lights working



from boats. On the onset we had great difficulty with our anesthetic dosage. The "Crocs" metabolism seemed entirely different when on dry land than when in the water — the drugs were several times as effective in the water. This was finally overcome and we felt that we had a very successful program for the first year.

As dentists we had quite an opportunity to observe the general dental health of both the "outback" Aussies and the aboriginal people. Dental care in general is rather poor, especially that type which could be considered cosmetic or esthetic, and dentists are rare in crocodile country. Consequently we did some emergency extractions under very crude conditions. We had taken several hundred pounds of emergency medical supplies but had to fashion dental forceps and elevators from a pair of needle nose pliers and a screw driver. In general the dental status of the natives was found to be far above that of our Alaskan natives, probably because the Australians are restricted to a fairly primitive diet free of refined sugars.

We enjoyed sixty days of continuous sunshine and have had problems getting re-accustomed to the old Alaskan drizzle.

MUKTUK MORSELS

By Bob Ogden

ANCHORAGE

DR. WILLIAM G. EDWARDS, Board Certified Orthopedic and Hand Surgeon is currently practicing at 3546 LaTouche. He was Medical Officer-in-Charge of the USPHS in Bethel from 1961-63 and for the last four years has been teaching orthopedics at Albany Medical College, New York.

DR. JAMES D. HANSON, is in General Practice at 1815 South Bragaw. Prior to coming to Alaska, he was an intern at the Virginia Mason Hospital.

DR. JAMES LUCAS, is a Board Certified Anesthesiologist practicing in the Anchorage area, who recently arrived from Chapel Hill, North Carolina.

DR. JOHN H. MILLER, has recently joined Drs. John and Jean Chapman at 207 E. Northern Lights Boulevard in the practice of Family Medicine.

DR. GEORGE RHYNEER, recently joined Drs. Bauldauf and Blankinship in the practice of Internal Medicine and Cardiology at 3300 Providence Drive. He has just completed a two year fellowship in cardiology at the University of Oregon Medical School in Portland, and prior to that was TB Control Officer for two years in Anchorage.

DR. JACK D. WREGGIT has joined the Langdon Clinic specializing in Child Psychiatry. Dr. Wreggit is a graduate of the University of Michigan and is formerly of Elmendorf Air Force Base.

DR. JACK A. SMITH, has opened his practice of Otolaryngology and Maxillofacial Surgery at 3300 Providence Drive. He was with the USPHS in Anchorage from 1965-67.

DR. HOWARD ROMIG, has recently retired from practice and is residing at his cabin on Kenai Lake.

DR. DONALD F. STONEFELD, is currently the Regional Psychiatrist and Regional Supervisor, South Central Region, for the State of Alaska. He attended George Washington School of Medicine in Washington, D. C.

DR. JOHN J. SMITH, has joined the College Medical Center in General Practice. He is formerly of Riverton, Wyoming, and was stationed at Elmendorf AFB from 1961-64.

DR. DAVID BOYD, has opened his practice of Psychiatry at 207 E. Northern Lights Boulevard in association with Dr. William Rader. He attended the University of Wisconsin Medical School and

was with the Arctic Health Research Laboratory in Anchorage from 1966-68.

DR. MILDRED McMURTRY, has recently begun General Practice in association with Dr. Royce Morgan. Dr. McMurtry recently practiced in Seldovia.

JUNEAU

DR. ROBERT N. PAGE, JR., a Board Certified Ophthalmologist, has begun private practice in association with Dr. John Banholzer. Dr. Page graduated from the University of Virginia, took the major portion of his residency at the University of Oregon and comes to Juneau from Hillsboro, Oregon.

DR. TOM A. STENGLE, is a Board Certified Otolaryngologist who recently arrived from Bemidji, Minnesota. Dr. Stengle trained at the University of Minnesota and served a one year fellowship at the Alaska Native Hospital in Mt. Edgecumbe.

DR. JOHN C. STEPHENS, is a Board Qualified Anesthesiologist who comes to Juneau from Temple, Texas. Dr. Stephens is a graduate of the London Hospital Medical College and took his residency at Scott and White Hospital in Temple, Texas.

DR. EDWARD C. THOMPSON, is a psychiatrist with the State Mental Health Clinic. Dr. Thompson completed his residency at Rollman Psychiatric Institute in Cincinnati, Ohio, and attended medical school at the University of Louisville.

DR. ROBERT CAVITT, has left his practice in Juneau and has moved to the state of Kansas.

DR. KEN MOSS, has had a fourth year medical student in the preceptorship all summer. The student is Miss Joan Wallington from the University of California at San Francisco. Miss Wallington's father is the Deputy Commissioner of Fish and Game for the State of Alaska.

KODIAK

DR. SPENCER R. FALCON has recently joined the Holmes Johnson Clinic. Dr. Falcon just completed his internship at Boston City Hospital and attended medical school at Boston University School of Medicine.

SOLDOTNA

DR. JOSEPH A. SANGSTER, has recently joined the Central Peninsula Clinic with Drs. Isaak, Gaede, and Riegle. Dr. Sangster is a Board Certified General Surgeon and completed his residency at Macon, Georgia.

FAIRBANKS

DR. SAM A. McCONKEY, has begun General Practice at the Tanana Clinic. Dr. McConkey is a graduate of the University of Virginia. He was recently discharged from the USAF at Eielson Air Force Base.

DR. DAVID CAMMACK, recently began General Practice at the Tanana Clinic. Dr. Cammack is a graduate of the University of Oregon and served two years with the USPHS in Alaska.

The Fairbanks Medical and Surgical Clinic recently received accreditation from the American

Association of Medical Clinics. This is the first clinic in Alaska to receive accreditation and is one of less than 50 in the United States. The accreditation was the result of a three day inspection by four representatives of the American Association of Medical Clinics — two physicians and two administrators.

The American Board of Family Practice announces that it will give its next examination for certification in various centers throughout the United States. The examination will be over a two day period on April 29-30, 1972. Information regarding examination can be obtained by writing: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex No. 2, Room 229, Lexington, Kentucky 40506. Deadline for receiving completed applications is February 1, 1972.

BOOKS RECEIVED

1. Manual of Medical Therapeutics: Nineteenth Edition, Edited by Jay W. Smith M.D., Department of Medicine, Washington University School of Medicine, Boston, Massachusetts 02106, 34 Beacon Street, Little Brown and Company, 391 pp.
2. Nephron Failure: Conservation, Substitution, Replacement. By Dossetor, John B. and Gault, Henry M., Charles C. Thomas Publisher, 301-327 East Lawrence Avenue, Springfield, Illinois, 303pp, price \$19.75.
3. Medical and Surgical Emergencies: Second Edition, Edited by John H. Schneewind, M.D., Year Book Medical Publishers, Inc., 35 East Wacker Drive, Chicago, 318 pp.
4. Review of Medical Physiology: By William F. Ganong, 5th Edition, Lange Medical Publications, Drawer L, Los Altos, California, 573 pp, price \$8.50.
5. Bronchitis 111, Third International Symposium: Edited by N.G.M. Orie M.D. and R. Van Der Lende, M.D., Charles C. Thomas Publisher, 301-327 East Lawrence Avenue, Springfield, Illinois, 393 pp.
6. Advances in Surgery: Volume 4: Edited by Claude E. Welch, Boston, Massachusetts, Year Book Publishers, Inc., 35 East Wacker Drive, Chicago, 413 pp.
7. Surgery Annual, Nineteen Sixty-Nine, Volume 1, Edited by Philip Cooper, M.D., Appleton-Century-Crofts, Meredith Corporation, 440 Park Avenue S., New York 10016, 472 pp, price \$14.00.
8. Surgery Annual, Nineteen Seventy, Edited by Philip Cooper, M.D., and Lloyd M. Nyhus, M.D., Appleton-Century-Crofts, Meredith Corporation, 352 pp, price \$13.00.
9. Basic Biochemistry: Third Edition; by Max E. Rafelson, Jr., Ph.D., Stephen B. Binkley, Ph.D., and James A. Hayashi, Ph.D., The MacMillan Company, 866 Third Avenue, New York, N. Y. 10022, 406 pp.
10. Hernia One Day Repair by Joseph Gaster, M.D., : Hafner Publishing Company Darien, Connecticut 06820, 179 pp.
11. Hernia Repair Without Disability, by Irving L. Lichtenstein, ii3 illustrations by Daniel C. Garcia, C. V. Mosby Co., St. Louis 1970, 210 pp, price \$26.50.
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RADIOGRAFFITI

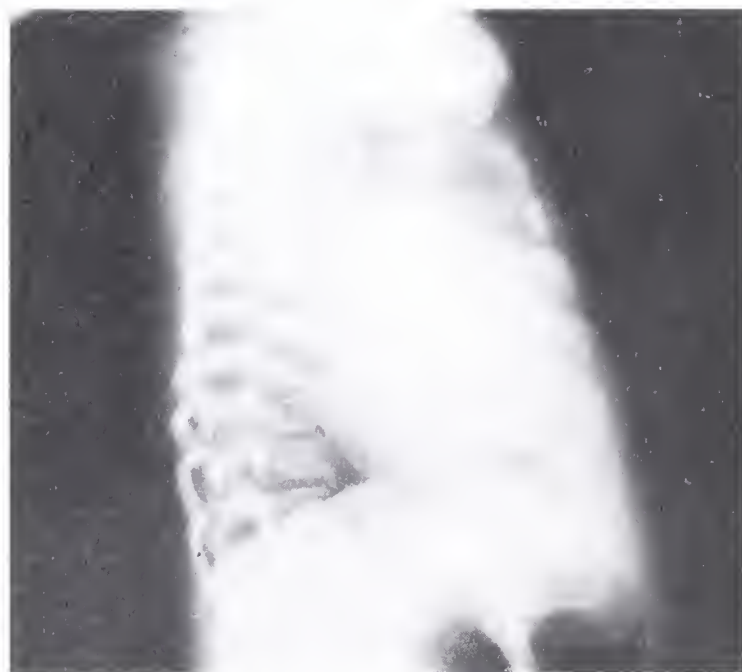
By Maurice J. Coyle, M.D.

The cases which follow will, I hope, be of interest. If not, please turn page and continue on.



CASE I

Young fellow brought to ER by some "with the scene" friends. Patient was comatose and coughing frothy white sputum and nearly left for new scenery. Not ill day before of admission.



CASE II

Six week old whose only murmur was one of discontent with its feedings. UGI and BE normal. Routine admission chest.



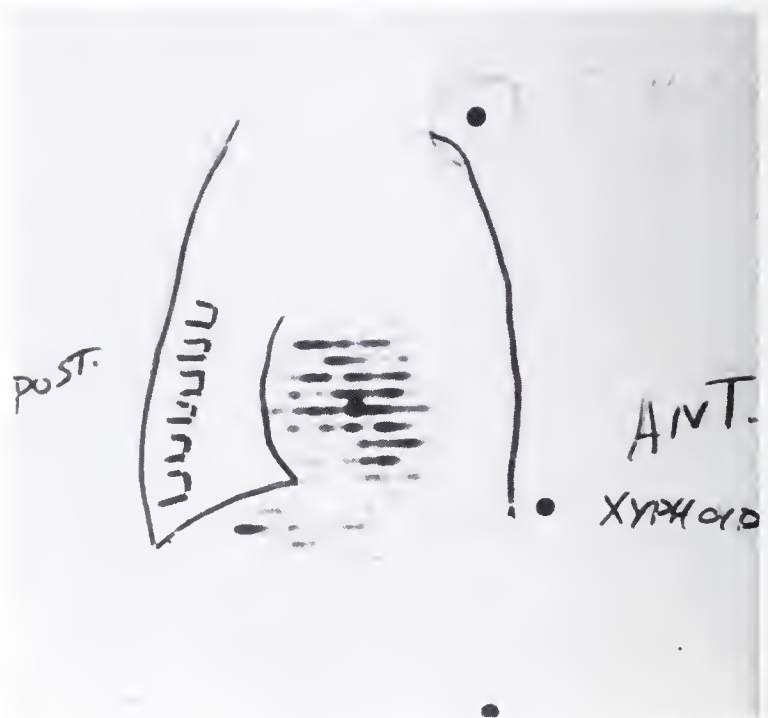
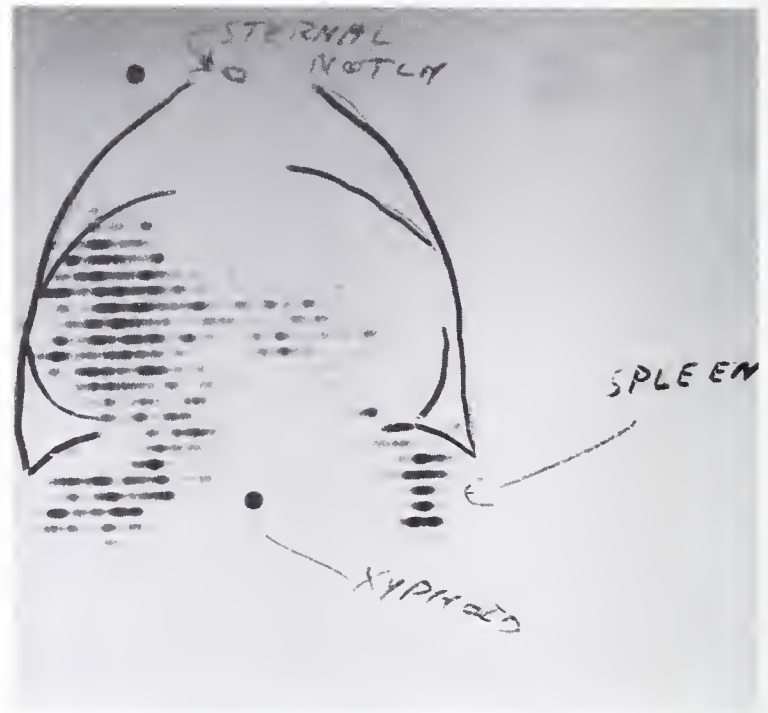
Next day — partial clearing



Five days later — normal

CASE I

The lung pattern is indicative of pulmonary edema. More importantly, the heart is normal in size. This combination should alert one to the possibility of heroin overdose, seen more and more frequently and certain to increase. The cause is not known but the possibilities include: hypoxic reaction, neurogenic cause, potentiated histamine release, and a hypersensitive reaction, perhaps to a contaminate used to cut the heroin.



CASE II

There is a large mass in the right anterior chest. The differential diagnosis includes lymphoma, teratoma, thymoma, neuroblastoma, anomalous venous return, and metastatic tumor. Closer observation, however, shows the RUQ to be somewhat rich in colon gas and poor in liver tissue. A liver scan clearly shows the main liver substance to be in the chest (chest film outlines superimposed on scan). A foramen of Morgagni hernia was successfully repaired.

THE LAKE OTIS HOSPITAL

By Mike Beirne, M.D.

My proposal that a third hospital, namely the Lake Otis Hospital, be constructed in Anchorage has caused controversy and raised some questions in the medical community.

Before attempting to answer those questions, I must point out that the Lake Otis Hospital is based on need. The immediate need for additional hospital beds in Anchorage is evident when the official figures from the State of Alaska are examined. Those figures, which are contained in an article I authored for the Alaska Forum in the Anchorage Daily News, Wednesday, October 6, and which are readily available from the State Commissioner of Health's office, clearly show the need for hospital beds both now and in the future.

The hospital bed shortage is dramatically demonstrated when beds are placed in the hallways or surgery is postponed or cancelled at Providence and Anchorage Community Hospitals. And these are not uncommon practices at the present time.

Furthermore, bed requirements estimated by the State do not take into account construction of the trans-Alaska pipeline or settlement of the Alaska Native Land Claims, both of which undoubtedly will add substantially to the population here and increase the immediate demand for hospital beds.

Given recognition of the need for additional hospital beds in Anchorage, we must address ourselves to the question of how this need might best be satisfied. Both Providence Hospital and Anchorage Community Hospital have submitted proposals to the Greater Anchorage Area Health Planning Council. Those proposals, submitted to

the council subsequent to the Lake Otis Hospital proposal, are not clearly defined and are long-range, providing no beds in the community until 1975.

The Lake Otis Hospital proposal provides for immediate construction of a privately financed 125 bed general hospital to be completed and operating within 18 months.

In addition, the Lake Otis Hospital will:

- Be a non profit corporation established under Alaska State Law.

- Be of simple design found in a two-story concrete and steel building and contracted through open bid per federal requirements.

- Meet all Federal and State hospital standards.

- Own all laboratory and x-ray facilities as is required to obtain accreditation.

- Be available to serve the general public or groups participating in the Health Maintenance Organization concept.

- Have an open staff.

The Lake Otis Hospital proposal is the only proposal before the local planning council that can meet the demand for hospital beds in a reasonable amount of time. It is the only proposal before the council that will avert a desperate situation in the near future. And, significantly, it is a proposal which has already won approval of the council.

Therefore, I believe that it is in the best interest of the community that the Greater Anchorage Health Planning Council urge Commissioner of Health Dr. Fred McGinnis to act on the Lake Otis Hospital proposal.



ANOTHER HOSPITAL?

By Keith Brownsberger, M.D.

The 125 bed facility proposed by Dr. Beirne has indeed raised a number of questions. No one can deny the need for additional beds in Anchorage, but their number, location, and control should be cause for serious consideration. The time has passed when private or public enterprise can build hospital beds as they please. The cost of any health facility is eventually borne by the public either directly or through third party payments and taxes. By law, the State must now issue a documented certificate of need before any bed expansion or new construction is undertaken, to avoid the continued burden of unneeded hospital beds.

In his Alaska Forum article, Dr. Beirne states that only 92 hospital beds in Anchorage conform to State and Federal standards for Hill-Burton Hospital construction funds. He does not say that the 85 nonconforming hospital beds at Anchorage Community Hospital include a first class intensive care unit; nor does he add that the decision declaring the Anchorage Community Hospital to be in an unsafe earthquake zone may have been unwarranted. Certainly it will prove a very expensive one for all Alaskans. One wonders how the great new hotels placed on the same fault in the same area met with such widespread approval, even acclaim!

Dr. Beirne does not mention that the 58 nonconforming beds at Providence were built in accordance with all then existing Federal, State and local standards. In the past few years these standards have changed slightly. Many of the two-bed wards at Providence now lack a few square feet for meeting present day Federal and State standards, yet they function perfectly well as first class, two-bed hospital rooms.

It seems a bit unfair that Alaskans should have to pay for 58 new hospital beds, or even for remodeling existing beds, just to qualify for additional hospital grants. Unfortunately these standards could change again next year. Do all Federal funds stop coming to the Alaska Native Medical Center and the U.S. Air Force Hospital when their beds do not conform to present Federal standards? Do they even have to meet those standards?

There are presently 711 active hospital beds in the Anchorage area: 85 at Community, 150 at Providence, 200 beds at Elmendorf U.S.A.F. Hospital (of which about 30 are occupied by Veterans) and 276 beds at the Alaska Native Medical Center. The latter serves 55,000 Alaska Natives as a referral center and 5,000 Anchorage

Natives as a community hospital. Any plan for medical care in Anchorage should consider all of these beds, as well as their complex inter-relationships through shared staff physicians and consultants, paramedical personnel and expensive equipment.

None of the 3 nursing homes in the Anchorage area are currently full to capacity. Many hospital beds could be made immediately available if these nursing home beds were properly utilized for convalescent care of hospitalized patients. Our insurance companies have largely prevented this, however, even though it would likely mean a reduction in total hospitalization cost for the patient. We understand that Blue Cross, for example, would rather keep their patients in hospital beds costing several times more, in order to keep these beds full and keep others of their subscribers out of them! Could that be how your friendly insurance company serves you?

The nursing shortage in our Anchorage hospitals is currently worse than the bed shortage. Dr. Beirne has suggested elsewhere that he will pay higher salaries and thus return to their profession many nurses now at home caring for their families. It seems far more likely that he will attract most of his nurses from existing hospitals. Our Federal hospitals have already backed the two civilian hospitals to the wall with their high salary offers and tax-free cost-of-living allowances. Many nurses and other hospital employees are still underpaid yet seventy-five to eighty percent of present day hospitalization costs are the salaries of hospital employees.

The trans-Alaskan pipeline construction will at least temporarily increase the need for hospital beds in Anchorage, Fairbanks and Valdez. I disagree with Dr. Beirne that the Alaska Native Land Claims is likely to make a substantial difference in Anchorage hospital bed requirements. The settlement will not make Alaska Natives suddenly rich. They will not flock suddenly to private medical care to spend their hard earned money. Many Alaska Natives are quite satisfied with the care they receive from the Alaska Native Health Service.

Dr. Beirne states in his article that both Providence hospital and Anchorage Community hospital have submitted proposals to the Greater Anchorage Area Health Planning Council. He is in error. Only Lake Otis Hospital and Anchorage Community Hospital have so far submitted proposals to the Council, although Providence

Hospital has asked for time on the agenda at the next Council meeting. Also the Community Hospital proposal did not mention 1975 as the target date for bed completion. It suggested that if financing was made available they could begin construction in the spring and have hospital beds in 24 months. Their past performance in this regard gives every indication that this would be a realistic figure.

Providence Hospital did present building plans at the Anchorage Medical Society meeting on September 21, 1971. These included a new nursing tower to be completed by 1975, and 40 to 50 modular-unit beds that could be ready within six months of approval. Their past record for construction competence and quality is also open.

At the same meeting, Dr. Beirne presented the Lake Otis Hospital construction plans and Anchorage Community Hospital presented their proposal. The membership of the Anchorage Medical Society was asked to express an opinion on the need for a third hospital in Anchorage as well as the plans for expansion of the two existing civilian hospitals. A special meeting of the Society was therefore held two weeks later. A quorum was present when the group voted *not* to approve Dr. Beirne's plan for a third hospital. At the same time the Society endorsed the Providence and Community Hospital applications for certificates of need for hospital bed expansion.

On August 16, 1971 the Greater Anchorage Area Health Planning Council voted to approve Dr. Beirne's proposal to build the 125 bed Lake Otis Hospital. However, at the next meeting on September 23, the Council voted to ask Commissioner McGinnis to withhold any certificates of need for new hospital beds pending study of all three proposals. This study is now underway. It's goal is to estimate the future need for hospital beds in Anchorage, and avoid over-building and unnecessary duplication and costly construction of medical services.

It is presently this editor's personal opinion that construction of the Lake Otis Hospital would increase the cost and decrease the quality of medical care in Anchorage. The present hospitals are capable of meeting both short term and long term area wide needs for hospital beds. The study now underway by the Greater Anchorage Area Health Planning Council should hopefully provide much information on which Commissioner McGinnis can base his decision.

No matter what the outcome, the people of Anchorage should be grateful to Dr. Michael Beirne for stimulating the Anchorage Medical Community into action. The entire State should benefit from this encounter. The Anchorage Medical Society in particular, owes Dr. Beirne a special vote of thanks for the sudden upsurge in its voting membership.



ACCIDENTAL HYPOTHERMIA: PART I

An Alaskan Problem

By Major Roger T. Gregory, MC

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Accidental hypothermia was considered a relatively rare condition when Rees reported four cases in 1958.¹ Subsequent reports by Emslie-Smith², McNicol and Smith,³ Fruehan,⁴ and Duguid, *et al.*⁵ brought more attention to the problem, however, and by the early 1960's, it was recognized that accidental hypothermia was not a rare condition in Great Britain. Prescott, *et al.*⁶ reported nine cases admitted to the general medical wards of a small hospital within a four month period. This high incidence (2.5% of all acute medical admissions) prompted these investigators to speculate that the condition was more prevalent than generally believed and "... that many cases pass unrecognized." A memorandum prepared by the British Medical Association in 1964⁷ stressed the high mortality associated with accidental hypothermia in the elderly and speculated that "... the incidence is very much higher than is commonly supposed." A Committee on Accidental Hypothermia of the Royal College of Physicians of London was formed to explore the problem and provided further information in 1966 as to incidence.⁸ They reviewed 126 cases, calculated an incidence of 6.8 per thousand admissions, and projected that some 9,000 cases were generated per year in Great Britain. A prospective survey conducted in 1968 by the Hypothermia Subcommittee of the Welfare Group of the Society of Medical Officers of Health found that in two London boroughs the incidence of hypothermia was 11.4% in a random group of elderly people living at home during three winter months. Keatinge estimated in a 1968 publication that approximately 1,000 persons per year died from immersion in British coastal and island waters. Although these deaths were usually attributed to drowning, it is his contention that hypothermia was the primary cause of death. After a study of the Lakonia and Titanic disasters, he concluded that most of the deaths were caused by hypothermia. Thus, by the late 1960's the problem of accidental hypothermia was well recognized in Great Britain as a common condition.

The opinions and assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of the Department of Defense or the Department of the Army.

Although generally accepted that the incidence of accidental hypothermia and low ambient temperatures are directly related, an arctic or subarctic environment is not always necessary as evidenced by reports from Africa^{12,13} and Kentucky.¹⁴ Recent reports from the subtropical state of Texas record 22 cases occurring during the winter months.^{15,16} These reports stress the fact that certain conditions (particularly malnutrition, alteration in level of consciousness, and alterations in the thermoregulatory system) increase susceptibility to reduction in internal (or "core") body temperature, such that a high index of suspicion is necessary to make the diagnosis in a relatively warm environment. A further implication from the literature is that accidental hypothermia is not necessarily confined to any particular geographical location.

Accidental hypothermia as an Alaskan problem has received very little attention. This is in sharp contrast to the problem of frostbite which has been the subject of considerable clinical review^{17,18,19,20} regarding diagnosis and treatment as well as significant research investigation in the areas of pathophysiology and prognostication.^{21,22,23} This notable discrepancy in emphasis between these two conditions prompted a survey of Alaskan physicians in an effort to clarify the magnitude of the problem of accidental hypothermia in Alaska.

According to a 51.1% response (184 of 360 physicians responding to a brief questionnaire), 61 cases of accidental hypothermia have been seen during the past 15 years by physicians presently in Alaska. These 61 cases were reported by 17.4% of those who responded to the questionnaire (32 of 184).

Although it is evident that no specific conclusions such as incidence or mortality rates can be drawn from an uncontrolled survey, certain generalizations may be suggested. The most obvious is that accidental hypothermia is a recognized condition in Alaska, as evidenced by the fact that at least 32 physicians presently in Alaska have made this diagnosis over the past 15 years. In contrast to Great Britain, where the problem of accidental hypothermia was gradually recognized over the past decade amid numerous publications on the subject, many Alaskan

physicians are apparently cognizant of the problem in spite of the paucity of attention directed to this area by the American literature. Notwithstanding the controversy in the current literature concerning the most appropriate therapy for hypothermic individuals, the most pressing problem in Alaska would seem to be establishing an accurate diagnosis.

To make the diagnosis of accidental hypothermia, obviously a reduction in core temperature must be established. Most investigators refer to any core temperature by rectal measurement below 94-95 degrees F as constituting a medical emergency. Unfortunately, this is as low as most clinical thermometers register (a fact enumerated many times in responses received from the survey questionnaire). Therefore, a low-reading clinical thermometer must be employed when the history and physical findings suggest accidental hypothermia. At this juncture, a problem may be encountered. Just as Dr. Simpson of Eagle, Alaska²⁴ found when he was confronted with a child suspected of being hypothermic, we likewise found that a low-reading clinical thermometer was "not available." A low-reading laboratory thermister may be used, but this is not as handy or as inexpensive as a simple, low reading clinical thermometer. Twenty-one thermometer manufacturers were contacted before a ready supply of these simple instruments could be located. A similar situation in England during the winter of 1963-64 was interpreted by Taylor as indicating infrequent use by medical personnel.²⁵

Despite the fact that Alaskan physicians are aware of accidental hypothermia, perhaps re-emphasis of the problem is in order. The subtleties and difficulties which attend this diagnosis go beyond merely locating a low-reading clinical thermometer. Patients with accidental hypothermia may appear to be clinically dead; there may be no detectable blood pressure or peripheral pulse, and no observable respiratory effort. A high index of suspicion is necessary to suspect hypothermia with the scant history frequently available. Physical examination, including measurement of a core temperature below 94-95 degrees F (recorded with a thermometer capable of registering low readings), and identifying electrical activity in the heart by electrocardiogram, confirm the diagnosis. In view of Alaska's climatic conditions, expanding trans-Alaskan travel, increasing popularity of the snowmobile, possible boating accidents in cold water, and psychological aberrations attending long severe winters, an increased appreciation of this problem may be appropriate.

The mortality attending cases of accidental hypothermia which have been diagnosed and treated is extremely high, less than 40% surviving

in most series.⁷ The most recent case reports reveal only 8 of 22 patients surviving.^{15,16} Associated conditions such as drug or alcohol intoxication, pneumonia, pancreatitis, renal failure, diabetes, or other endocrinopathies, and frequently fatal cardiac arrhythmias, present a profound therapeutic challenge and demand close attention by the physician. Failure to recognize these complications and the serious nature of the problem can only contribute to the high mortality figures generally reported. An increased appreciation of this diagnostic possibility might well result in more accurate identification of hypothermic patients, and allow more emphasis to be directed towards successful management. In this regard, more effective methods of resuscitative rewarming are presently under investigation at the Arctic Medical Research Laboratory, Alaska, which may improve survival from accidental hypothermia, clearly an Alaskan problem.

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SURGERY OF THE SEVENTH CRANIAL NERVE

By David D. Beal, M.D.
George A. Lyon, M.D.
J. David Williams, M.D.

Surgery of the facial nerve can be divided into three distinct problems that are related to the peculiarities of its anatomic course. Surgery of the peripheral (or extra temporal) facial nerve deals primarily with that component after its emergence from the stylo-mastoid foramen, while middle (temporal) segment involves the course of seventh nerve within the fallopian canal as it traverses the temporal bone. Operations on the central (or cranial) portion of the facial nerve must be directed at its proximal segment between the geniculate ganglion and brain stem, i.e. in the internal auditory meatus. New techniques of diagnosis and surgery have been evolved in the last few years which have changed the method of handling some of the problems related to this nerve. While it is convenient to discuss surgery of the facial nerve segmentally, it is actually the continuity of this nerve from the brain stem through the compacted vital structure of the temporal bone that offers the challenge. Diseases affecting this nerve do not respect artificial boundaries and a surgeon must have the expertise to pursue preservation and reconstruction of this nerve wherever necessary.

Surgery related to the peripheral portion of the seventh cranial nerve involves dissection of the nerve from the surrounding parotid gland. This dissection is facilitated by early identification of the nerve at the stylomastoid foramen; haphazard and fortuitous discovery of the peripheral branches often results in needless injury to the seventh nerve which for benign lesions is no longer acceptable. Nerve grafting with segments of other nerves (sural or greater auricular) has given favorable results in 12 to 18 months, with recovery of tonus in the facial muscles, while accessory, or hypoglossal-facial nerve anastomoses often result in properly performed facial mimic movement over a course of time.¹

Case No. 1

A thirty-one year old male had noticed the onset of pain with a small mass located below his left ear four months prior to his admission. Three months after the onset he noted a slight dropping

of his left lower lip. Parotid sialography indicated a skip lesion in the ductal system prior to surgery and carcinoma of the parotid was suspected. Surgery of the parotid was carried out and squamous cell malignancy was found to involve the seventh nerve at the stylo-mastoid foramen. For proper resection of the tumor and reconstruction of the nerve it was necessary to dissect out the mastoid portion of the facial nerve. One centimeter into the canal transection was carried out. A free nerve graft of the greater auricular nerve was placed in the defect from the vertical descending portion of the seventh nerve to the upper four peripheral branches temporal, ocular, zygomatic, and buccal. Twelve months later the face had an equal contour at rest with the lower three branches having re-grown, but the forehead remained flaccid. Mimic movements were absent.

Surgery of the temporal portion of the seventh nerve usually involves the decompression of its bony canal to prevent a permanent paralysis. The swelling of the nerve in this region is spontaneous (Bell's Palsy) or is secondary to iatrogenic trauma. Very few people with Bell's Palsy need surgery as 85% have spontaneous recovery without decompression. (Therefore, recent work has been centered on methods to indentify those 15% who have permanent palsy and could be helped by early decompression.) Several tests of nerve function have been developed. These measure the actual electrical activity of the nerve, as well as the function of the lacrimal and submaxillary glands.

Case No. 2

A ten year old boy over a two day period developed a complete left facial palsy following head trauma. He struck the left temporal region of his head on a metal pole while playing in his basement. Initial electrical measurement necessary for excitation of his paretic seventh nerve was carried out three days after the accident. The Hilger nerve stimulator indicated a 1.5 Millamphere (MA) stimulation would cause the right or normal side to move. The left required 2.9 (MA) for similar movement. (The following day the boy's

left side moved at 2.6 (MA) and although the paralysis appeared complete and to the eye was not recovering. Five days later, only 1.9 (MA) was needed for stimulation and the parents were assured of total recovery. This subsequently occurred.)

It has been found by numerous investigators that until the difference between the normal and paretic seventh nerve reaches a value of greater than 3.5 (MA) the likelihood of spontaneous recovery is 95%.²

Case No. 3

This 42 year old lady was seen one week following the onset of complete paralysis of the right side of her face following exposure to a "cold wind". On her original test there was a 5 (MA) stimulation required for the right side to move as well as the left at 2.1 (MA). Four days later 8 (MA) were required and six days later 10 (MA) (machine maximum) on the right did not effect stimulation. The patient was taken to surgery and the temporal portion of the facial nerve was decompressed from the mastoid tip to the geniculate ganglion. At surgery when the fallopian canal was opened the nerve bulged. At one year the patient had an 85% recovery with a slight paresis of the temporal portion of the nerve.

Otolaryngologists began to operate on the central portion of the seventh nerve when Dr. William House³⁻⁴ developed several new approaches to the cerebellopontine angle. These approaches, often in coordination with standard neurosurgical approaches, have made removal of acoustic neuroma and other angle tumors possible with a 70% salvage of the seventh nerve.

Paramount in this surgery has been the discovery of acoustic tumors at a very early state. Classic signs of these tumors were severe deafness, headache, ataxia, and papilledema. Now they are discovered early by subtle physical signs, as the following case will elucidate.

Case No. 4

This 44 year old lady had a slight left hearing loss for four years. She also noted tinnitus and

complained of some balance difficulty. Routine work up revealed a mild 40db sensorineural loss in the left ear with good discrimination of words (76%). An X-ray of the internal auditory meatus showed an enlargement of the left internal auditory canal. Further testing was carried out. A complete neurological test failed to reveal additional abnormalities. Caloric tests carried out with electronystagmography revealed a slight left vestibular paresis. A complete battery of hearing tests were conducted to identify the hearing deficit as cochlear or retro-cochlear. The speech discrimination test which is usually low in tumor cases was high. Tone decay which is usually present in tumor cases was absent. The SISI (Short Increment Sensitivity Test) which is low in tumor cases was 100%. The Bekesy tracing indicated a cochlear lesion and the test for recruitment was positive when it should have been negative. The spinal fluid protein was 50 mgm %. In spite of the negative evidence, it was felt the progressive sensorineural hearing loss and X-ray change justified a pantopaque study of the posterior fossa. This study displayed a 1 to 2 CM tumor in the cerebellopontine angle. Subsequently a translabyrinthine exposure of the cerebellopontine angle was accomplished at surgery and total removal of the acoustic tumor was carried out. Preservation of the facial nerve by an otolaryngological and neurosurgical team effort was facilitated by recent technology including high speed air drills, diamond bits, suction - irrigation and the operating microscope. Most of these diagnostic and surgical tools and techniques have been available in the past 20 years, however their refinement in the last decade has given surgery of the seventh nerve a new expression.

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Dr. Arthaud and his associates have written an interesting article. Anyone dealing with the Alaskan Native population should be aware that almost all are Kell Negative. This compares with an incidence of Kell antigen in the non-native group of about 10%. Although the frequency of (C) and (c) Antigen is greater, the incidence of sensitization to Kell is comparable. The former are routinely tested for in blood banks. Perhaps we should also test all donor blood for Kell Antigen.

Only in the premenopausal female is there risk to the recipient if anti-Kell antibody develops. Next to RH (D), Kell antibody is the commonest cause of hemolytic disease in the newborn. It can also produce lethal hemolytic reactions if a sensitized patient receives un-crossmatched Kell-positive blood as in an emergency. Fortunately, it is rarely necessary to administer un-crossmatched blood, and even when sensitized, 90% of available bloods will still be compatible. — Carl Beck, M.D.

KELL ANTIGEN PROBLEMS ENCOUNTERED IN AN ALASKA NATIVE HOSPITAL

By J.B. Arthaud, J. Miller, and F. Lanier *

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Since the discovery of the Kell erythrocyte antigen in 1946,¹ numerous population and ethnic groups have been studied for the incidence of this and the other associated antigens within the Kell system. The anti-Kell antibody was detected as 19 of 54 antibodies in a 34 month period (April, 1967 - February, 1970) in the blood bank of the Alaska Native Medical Center, a 276-bed hospital maintained by the United States Public Health Service in Anchorage, Alaska. A limited survey of Eskimo patients was conducted during March to May, 1970.

MATERIALS AND METHODS: Anti-Kell antisera obtained from Ortho Diagnostics* was used in an anti-human globulin tube agglutination test on the erythrocytes of 488 Eskimo patients. All of the red cells were obtained either from clotted or EDTA anticoagulated blood specimens collected for diagnostic testing. Twenty-nine of the determinations were done at the USPHS Hospital, Kotzebue, Alaska; the other 451 were done in Anchorage. Blood quantum of the patients was obtained from the Admitting Office records.

RESULTS: Only four of the 488 persons tested revealed the Kell antigen: one of 419 full-blooded Eskimos; two of 53 half-blooded Eskimos; and one of 15 quarter-blooded Eskimos. (Table 1.)

DISCUSSION: In 1952, 67 Eskimos were tested for the presence of the Kell antigen and it was not found.² Lewis, Chown, and Kaita³ found eight examples of the Kell antigen in 416 children of admixed Eskimo, Indian, and Caucasian parentage in Canada and Alaska during a study of blood group antigen inheritance. A study of 241 Eskimos by Corcoran et al in 1959⁴ did not reveal the Kell antigen. To our knowledge, the Kell antigen was encountered a maximum of 12 times

in the 1532 tested Eskimos. Three of our four Eskimo patients exhibiting the Kell antigen are known to have Caucasian ancestry. The earlier reported eight examples could have been in persons with Caucasian forebears although this is not explicitly stated.³

Of the 19 patients (7 Eskimos, 8 Indians and 4 Aleuts) who had anti-Kell antibodies identified at our hospital, only one failed to have a history of previous transfusion, pregnancy, or other medical or surgical condition for which a transfusion might have been given.

That six of 13 antibodies detected after 3,461 transfusions in 1,250 patients were anti-Kell is a good indication of the potent antigenicity of Kell.⁵ The problem of the anti-Kell antibody production can be expected to persist in any patient population which primarily receives blood from a different ethnic group in whom the antigen is markedly more prevalent.

Kell antigen in Eskimos

Blood Quantum	Total	Present	Absent
Full	420	1	419
½ or more	53	2	51
¼	15	1	14
	488	4	484

SUMMARY

Prompted by the detection of 19 anti-Kell antibodies in transfusion candidates at the Alaska Native Medical Center from April, 1967 to February, 1970, a survey of 488 Eskimos during March-May, 1970 revealed the Kell antigen in four persons, only one of whom was full-blooded. As long as Caucasian donors, who have an approximately 9% incidence of the Kell antigen, are primarily used in the transfusion service, continued production of the anti-Kell antibody can be expected in the recipient population.

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*Use of trade names is for identification only and does not constitute endorsement by the Public Health Service or by the U. S. Department of Health, Education, and Welfare.

Book Review

Emergency Care and Transportation of the Sick and Injured

Edited by Charles A. Rockwood, Jr., M.D. 320pp., illustrated. Chicago: American Academy of Orthopaedic Surgeons. 430 North Michigan Avenue, Chicago, Illinois 60611. 1971. \$4.95 prepaid.

The Committee on Injuries of the American Academy of Orthopaedic Surgeons has produced an extremely comprehensive and readable text. Although designed primarily as a textbook for training the emergency medical technician, it should also prove valuable to those not commonly involved in emergency care and transportation of sick and injured individuals. Written by more than one hundred contributors, the text is divided into fifty eight chapters. It has over three hundred illustrations detailing the practical application of emergency care and rescue techniques. Among subjects covered are the emergency treatment of fractures, burns, poison ingestion, heart attacks, strokes, and explosion injuries, as well as record keeping, vehicle maintenance, and legal responsibilities. Its potential audience includes ambulance drivers and attendants, nurses, police officers, firemen, safety engineers, rescue squad members, and other persons responsible to the public for administration of first aid treatment. Necessary information is included to standardize emergency vehicles and emergency personnel training programs so that they comply with the 1966 highway safety act. It complements the training of emergency technicians and procedures recommended by the Committee on Emergency Medical Services of the National Academy of Sciences and the National Research Council, and it will serve as the primary textbook for the U.S. Dept. of Transportation basic training program for all ambulance personnel. Lesson plans are available to augment this text in first aid classes.

During the past six months this text has been read widely by personnel of the Anchorage Borough Fire Department.

— William B. Reinbold, M.D.

As an E.M.T. (Emergency Medical Technician) and long time teacher of first aid, I am highly pleased with this text, which gives a single, well-indexed reference for the body systems, topographic anatomy, and diagnostic signs of acute injuries. The dual use of technical and common terminology is helpful for instruction and leads the E.M.T. toward better understanding of medical literature and enhanced professionalism. I have rebound my copy in a plastic spiral binder which permits the use of the illustrations with an opaque projector in the classroom.

— Charles D. Whittaker

Capt. Greater Anchorage Borough Fire Department.

Kell Antigen

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CHILD SENSE

(What Spock and Ginott Didn't Tell You
About Bringing Up Today's Kids)

By William S. Homan, M.D., 296pp. 1969. New York: Basic Books.

This book, also obtainable in paperback (Bantam), is full of just good commonsense, plus some psychiatrically-sound principles having to do with everyday problems of raising children. Dr. Homan's idea of offering love freely to children rather than on demand, for example, is something that parents may forget in the hurry of every day living. He talks about direct and indirect expressions of love, such as "tucking a child into bed at night while forbearing to review with him his daily misdeeds. Tucking him in long after he is too old to require such attention." "Biting your lips and waiting for a better moment instead of calling him down in front of his peers." Another excellent thought is that of "face saving" for the child in front of others, while not overlooking the necessary discipline when the others have left.

Particularly good are his definition of nagging in contrast to teaching, and his concern with criticizing the act of a child but not the child's self-esteem. The sections on common problems of family relationships and the adopted child are excellent.

Dr. Homan's remarks on discipline are particularly good in defining discipline as "part of love" and different from punishment. Punishment he defines as the infliction of pain because one is angry; it is to pay someone back. This definition deserves much thought. He recommends considering the child's needs rather than one's own. This may sound simple enough when one thinks of it in the abstract; it would help if Dr. Homan would mention how difficult it is and how often a parent will fail because his own needs are great, and he must then cope with his own feelings of failure.

Dr. Homan's attempts to explain how a parent should cope with his own anger at a child would be difficult for most people to accomplish, in my estimation. To be angry at a child and then assure him that you love him in the same breath or the next breath seems to me to be beyond the possibility of most human beings to do honestly. In fact, a child may wonder about the sincerity of a parent who does that. People do have to allow a certain amount of time to cool off before they can be honest in expressing love again. The important point, however, is to remember to express that love; the timing can only be decided by the individual.

One has to take with a grain of salt Dr. Homan's evaluation of IQ scores. He does not include the possibility of cultural differences, making IQ tests appear lower than the Caucasian average for which the IQ test was originally set up. Also, he indicates that the IQ test once taken and established as valid does not change except inasmuch as a person may feel better when he takes the next test. There has been much changing thought in the last five to ten years on this score. As stated in the superb Canadian compendium of study and thinking called "One Million Children" concerned with children and their education, there is no completely valid-for-a-lifetime intelligence test. Despite the criticisms offered, *Child Sense* is another good book for the parent, especially the new parent, to have, to browse through, to gain courage to face the next problem, and perhaps primarily as a stimulant to thinking through his own situations. No book on child rearing can be a "cookbook", giving exact recipes. It can only serve as a springboard for application to one's own psyche and one's own family. Dr. Homan's book admirably serves this purpose.

—Elinor B. Harvey, M.D.

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- Dr. Jon Aase, Deputy Director, Washington/Alaska Regional Medical Program.
- Mr. Robert Ogden, Executive Director, Alaska State Medical Association.
- Mr. Theodore Moore, Communications Consultant, Anchorage Telephone Utility.
- Mr. Matthew Hencks, Medical Social Worker, USPHS.
- Mr. Craig Mills, President, Suicide Prevention and Crisis Service.

This group has met twice within the last month and will continue to meet as necessary. Realistic and dedicated seems to describe them well.

We have made a small beginning and see a great deal of work and many problems ahead, but the Easter Seal Association has committed itself and its resources to Information and Referral — a basic need in Alaska. If the interest and cooperation shown thus far are any indication, the mission will be accomplished.

Sincerely yours,
Mary Tomasiewicz, MPH, Coordinator



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